UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT TACOMA

EMILY TORJUSEN,	3:18-cv-05785-BHS
Plaintiff,	Tacoma, Washington
v.	
NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK,	March 30, 2022
Defendant.	Jury Trial
	9:00 a.m.

VERBATIM REPORT OF PROCEEDINGS
BEFORE THE HONORABLE BENJAMIN H. SETTLE
UNITED STATES DISTRICT JUDGE

Proceedings stenographically reported and transcript produced with computer-aided technology

Barry L. Fanning, RMR, CRR - Official Court Reporter
(253) 882-3833 Barry_Fanning@WAWD.uscourts.gov
1717 Pacific Ave - Tacoma, WA 98402

APPEARANCES

For the Plaintiff:

ANTHONY S. PETRU
SCOTT H. LEVY
Hildebrand McLeod & Nelson LLP
350 Frank H. Ogawa Plaza
Fourth Floor
Oakland, California

JOSEPH ANDREW GRUBE
Breneman Grube Orehoski PLLC
1200 Fifth Avenue
Suite 625
Seattle, Washington

For the Defendant:

JOHN A. BONVENTRE
Landman, Corsi Ballaine & Ford
One Gateway Center
Fourth Floor
Newark, New Jersey

ANDREW GORDON YATES
Lane Powell, PC
1420 Fifth Avenue
Suite 4200
Seattle, Washington

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MORNING SESSION

MARCH 30, 2022

THE COURT: Good morning, everyone. We are ready to proceed with the next witness, are we?

MR. PETRU: We are, your Honor.

THE COURT: Bring in the jury.

(The following occurred in the presence of the jury.)

THE COURT: Everyone, please be seated.

Mr. Petru, your next witness.

MR. PETRU: Yes, your Honor. We are going to call Dr. Aaron Filler.

THE COURT: Good morning, Jurors. Did you have a good evening, rested up, and ready to go?

Good morning, sir. If you would step forward in front of the bench here and raise your right hand, the oath of witness will be administered.

AARON FILLER,

having been sworn under oath, testified as follows:

THE COURT: Thank you. If you would please take a seat here at the witness chair.

DIRECT EXAMINATION

BY MR. PETRU:

Q. Good morning. Can you please explain to the jury what you do for a living, Dr. Filler?

A. So I'm a neurosurgeon.

Q. Where did you receive your training?

A. So I went to medical school at the University of Chicago. I did a Ph.D. at Harvard, and I did my neurosurgery training at the University of Washington in Seattle.

Q. How long were you associated with the University of Washington in Seattle?

A. So it was an eight-year training program.

Q. Eight year. Where did you live during that time?

A. So most of the time -- the majority of the time, I lived in Seattle, Queen Anne, and then I spent another couple of years in London. We had a program -- exchange program at the hospital outside London near Wimbledon, where all the residents would go for a year. For two years, I did research there so I stayed additional time.

Q. Can you please explain to the jury what neurosurgery is?

A. So there are three types of doctors that specialize in the brain and nervous system. We have neurologists, who see people and mostly prescribe medicines or do EEGs, electrical measurements of the brain. You have neuroradiologists, who specialize in imaging of the brain. And you have neurosurgeons who do all of the above. We see patients, we interpret our images, and we do surgeries or injections or a wide variety of treatments to fix

problems with the brain, spinal cord and nerves.

Q. Do you have any special training or experience in the area of neuroradiology?

A. So I did a one-year additional fellowship after the residency in neuroimaging, which was done in the UK.

Q. In your practice, since you finished the additional year, have you been involved in the analysis and the development of neuroimaging of the brain?

A. Yes. When I was a resident here in Seattle, I developed an idea of a new method of imaging the brain, an advanced type of MRI which I worked on. And this proved to be successful. And while I was in England in particular, we completed all that work, did more finishing work back in Seattle, and that is now a major new type of imaging called DTI or diffusion tensor imaging that allows us to see the internal structure of the brain. It's something that is in universal use all around the world. It saves tens of thousands of lives per year.

I also developed a new type of imaging for nerves in the body called MR neurography, which is also in worldwide use which helps identify complex nerve problems. So I have been involved in that.

These were my original ideas, and then I developed them, and then have been very involved in the clinical use of that. And so I currently write textbooks and do

teaching in neurosurgery about how to use the methods.

Q. It has been suggested by counsel for Amtrak yesterday that the test, the DTI test, has been rejected by, he said, the Academy of Radiology. Is it correct that the DTI has been rejected and is not used and not relied upon?

A. No. I mean, it is a life-and-death precision study that is used every day on numerous patients in every hospital or neurosurgery that is done. It is done for any -- if anyone in the military suffers an injury. It has been mandatory over the past ten years. It is required after anyone in the military -- I am a former -- I was a lieutenant colonel, I was the commander of neurosurgery based in Fort Lewis here and Madigan Army Medical Center, so I certainly know that this is a critical type of imaging used whenever anyone in the military is harmed and is widely used as a high-precision relied-on method in every hospital that does anything neurosurgical, certainly in the world, and a vast number of neurological specialists use it as well.

Q. So rather than something that is not relied upon and rejected, the U.S. military utilizes it whenever there is an officer or enlisted man or woman who suffers a brain injury?

A. Right.

Q. Potential brain injury.

A. And if you look on Google, there is 156,000 publications using this to study for all different medical problems. Tens of thousands of first-ranked research studies. The idea of an organization called the Academy of Radiology, which I don't think there is such an organization, would say you can't use it, but all these thousands of people die, interferes with the practice of medicine around the world, that is a very remarkable thing to say.

Q. Has it been found to be successful in understanding how the brain is affected by blunt trauma and using the information to try to determine ways to treat patients who suffer from TBIs?

A. Yes. I mean, the general medical use that goes back to -- I invented this, the first one of these images in 1992. But the widespread clinical use for guiding brain surgery started in 2007. The Chinese government identified the technology, did this massive trial, research in the University of Shanghai, which is their Harvard, and showed it reduced the risk of death of during brain surgery by 40 percent, reduced the risk of paralysis by 60 percent.

So from that point, within a year, studies were reproduced in Europe and the U.S., it became mandatory to use DTI because you couldn't justify doing surgery, it was

double the risk of death and triple the risk of paralysis because you didn't want to use the imaging method. But the military started doing it in 2013, not just for guidance or treating brain tumors, but they started using specifically this, the brain DTI for diagnosis and treatment of everybody with a mild traumatic brain injury.

You hit your head, you have some symptoms, you are dazed, you are confused, your behavior is off. And we saw this just recently, a year or two ago, when Iranians bombed an air base in Iraq. Everybody is fine, nobody got injured, and then a few days later they said, oh, no, there is all these head injuries.

What it was, they went to the soldiers who were developing headache, nausea, confusion and memory loss and did the DTI scans and found the injuries. That is exactly what happened. That is consistent with this policy. That is why the military has made this mandatory for the diagnosis of mild traumatic brain injury, which is exactly what this is about.

So I really, you know, don't know how that position that it isn't used is believable, where it comes from.

Q. You indicated that you were involved in developing the technology in, I think you said, 1992. Where were you working at the time that it was developed?

A. The project started in Seattle, and then I had my

period of time where I was sent over to work at Atkinson Rowan Hospital in Wimbledon which, by the way, is the same hospital where Hatfield built the first CT scanner, built it out of x-ray machines and did -- The first CT scan was done there in that hospital in 1974. And I was over there doing just neurosurgery as a resident as -- we would have our time over there. But then I brought my research project over there, and the first successful scans were done there. And then when I got back to the University of Washington, I worked with some of my colleagues there. We took it even further and got the detailed brain imaging working over the course of a year and filed a patent.

Q. Who owned the patent?

A. So the patent was owned by the State of Washington.

Q. So the DTI technology that you helped develop 20-some-odd years ago, 30 years ago, now is in the mainstream and the original patent was owned by The state of Washington?

MR. BONVENTRE: Objection. Leading.

THE COURT: I think he just summarized what was testified to. Objection overruled.

BY MR. PETRU:

Q. Is that correct?

A. Yes.

Q. Now, you and I met a few years ago when you were

treating one of my clients, correct?

A. Yes.

Q. We don't need to go into that case. That had to do with a complex --

MR. BONVENTRE: Objection, your Honor.

BY MR. PETRU:

Q. How did we meet?

THE COURT: The objection --

MR. PETRU: I will withdraw the question, your Honor.

BY MR. PETRU:

Q. How did we meet?

A. I helped take care of a young woman who was an engineer on a train and the train was separating as she was struggling to hold the train together, and suffered an injury affecting the nerves, the brachial plexus nerves. And I did imaging, treatments and injections for her to fix up the nerve injuries she suffered. And I ended up testifying in the trial.

Q. And that included surgery, twice?

A. Yes.

Q. And during that time, you told me when we were visiting about this DTI process, correct?

A. Yes.

Q. And we asked you, after Dr. Scovel determined that

there was evidence of brain injury, to do a DTI evaluation of her to determine whether or not --

MR. BONVENTRE: Objection, your Honor. Leading.

MR. PETRU: I will withdraw, your Honor. That's fine.

BY MR. PETRU:

Q. In your practice, do you have -- are you asked to review or do DTIs after neurocognitive evaluations?

A. Yes. We get sent a lot of patients who have any sort of brain injury, chemical exposure; it might be trauma, where they need sort of the very advanced imaging techniques. And although the DTI imaging is available pretty much, you know in terms of the machines, all the MRI scanners virtually in the world now do this, but the processing is time-consuming or specialized. And so there are maybe dozens or hundreds of specialists in analyzing it when there might be 10,000 doctors that look at routine MRIs.

Q. When you say "processing," that is taking the information that is derived from the scanning and using the appropriate programs to analyze it?

A. Yes. And I think it is because we do a very thorough analysis that -- You know, we get patients from out of areas -- I live in LA -- for imaging analysis.

Q. Let's get this out of the way. Your clinic in LA,

how many doctors are there in the clinic?

A. Well, that's really a private practice. It is myself and then my staff.

Q. So for you to come here, you have to close down the clinic essentially for the day?

A. Yes.

Q. And you have a flat rate you charge for a day when you cannot be in your clinic?

A. Yes. We charge $15,000 for a full day away for testimony.

Q. And that's what you are charging us to be here?

A. Yes.

Q. You also prepared a PowerPoint to help explain the analysis of what you did, correct?

A. Yes.

Q. I will be asking you questions about your opinions and conclusions here. Will all of your opinions be based on a reasonable degree of medical certainty?

A. Yes.

Q. The first thing I would like to have you talk to the jury about is how a blow to the head can result in a brain injury. There is an exhibit we have shared. I will show it to you just to identify it. Have you seen this video?

A. Yes, I have.

Q. And does it accurately depict the effect on the brain

on a superficial level from a blunt trauma to the head?
A. Yes.
MR. PETRU: Your Honor, I would like to publish demonstrative Exhibit 40 -- excuse me, 27 -- 40, please.
THE COURT: 27?
MR. PETRU: 40. My mistake, your Honor.
THE COURT: Any objection?
MR. BONVENTRE: No objection.
THE COURT: It may be published.
BY MR. PETRU:
Q. It doesn't have any voice over, so if you can explain what is happening as we look at the video, I would appreciate it.
A. What this really is covering -- there are two things to understand behind what the video is showing.
Firstly, when the skull is impacted, the brain is surrounded by fluid, and the skull starts to move before the brain does, and then the skull goes and hits the brain. It is sitting there in fluid waiting, if you break it down in time. The skull gets hit, the skull hits the brain. The brain is then driven across and actually hits the other side of the skull. So it can be injured both on the impacting side and the opposite side. So the contrecoup, the coup contrecoup, the hit and the counter hit. So there is often a pair of injuries. And the brain

does go through --

Q. I paused it here. What do we see here?

A. This is distinguishing two areas of the brain. The gray matter is the outer surface that has all the tiny neuron cells that connect with each other, all the connections that sort of make decisions and pass things around and organize information.

And then the white matter are the long sort of telegraph wires or connections between parts of the brain, so that part of the brain goes about deciding to move your arm or hand, and then it sends a signal down a long wire to your spinal cord to actually help make your arm move. Both of those areas can be injured.

That is one aspect of the fact -- and you see a couple of dark areas in the center, those long linear dark areas. Those are fluid-filled ventricles, as they are called. It goes to the point that the brain actually gets distorted or twisted when it is impacted, because it is not just a solid, you know, rubbery sphere. Some structures are stiff, some are mobile, some can tolerate some bending, some can't. So you get sort of characteristic patterns of injury depending on where the impact comes from.

These are -- have certain specific effects on function. So the brain is not completely uniform, when

part of it generates speech, when part understands speech, and another part interprets incoming images. In the back of the brain, we have the sort of movie screen.

All these different functions, movement, all of our emotional life, anger, irritability, depression, all these things -- although some things we know have psychiatric causes, events in your life. On the other hand, we also know that injuries can actually impact and break something or bruise something in the brain that results in that same kind of symptom. You have an injury to a particular location, it will cause depression; an injury to a different location may cause problems with calculation. They each have their place and can be injured in a brain injury.

Now, I think the next part in here goes into the even finer detail of what happens in an injury. So we have these cell bodies, which have the connections that reach out, hundreds of different connections with neighboring neurons. And then that long set of like train cars there, that's an axon that connects from one place to another. The little separate segments are cells that wrap around the axon, wrap around the nerve extension, and have insulation in them.

So when the insulation gets bruised, the signal doesn't transfer very well across the bruise. It's like

breaking the insulation off a wire causing shorts.

And so this is the kind of thing that DTI shows very well, is when the insulation is impaired and the neuron isn't cut, it isn't necessarily severed, it is just not functioning well. That's one of the fantastic things about this type of imaging is we can see when there has been an impairment that slows or alters signal transmission. And some of these will then -- will gradually repair themselves, just to really restore the lining, and then the nerve connection will start working again. But this is the type of thing -- injuries in the white matter -- that the DTI tract images, as we call them, are particularly good at detecting.

And then we have another measure you will hear us mention called FA or fractional anisotropy, and it looks at these kind of partial injuries in the white matter tracts, the long connections.

Q. I meant to ask you earlier, when you were working on developing the patents and working with the legal system, did you do anything to allow yourself to better understand the legal system and the whole work around patents?

A. Well, a few years ago, I actually went to law school because we had a lot of litigation about the patents. Basically, we had a lot of major corporations, Siemens, GE, Phillips, Hitachi, Toshiba commenced -- technology was

in urgent demand. And I think they did the right thing by rushing out the technology around the world. But then we had a duty to the State of Washington to make them pay for their share of the use of the invention. And that's where I was involved with that. And so I got a JD to help with the attorneys working in that process.

Q. As I indicated earlier, you prepared a PowerPoint to help explain your findings with regard to Emily Torjusen, correct?

A. Yes.

Q. It is Exhibit 40.

THE COURT: Your Honor, I would like to publish it and go through it with Dr. Filler.

A. So --

THE COURT: Just a moment. Exhibit 40.

MR. BONVENTRE: No objection other than the first slide, Judge, the wording in the first slide. I will withdraw it. No objection.

THE COURT: I thought Exhibit 40 was the exhibit I had been watching?

MR. PETRU: Your Honor, my dyslexia. This is Exhibit 41, the PowerPoint. You are correct.

THE COURT: It may be published.

MR. PETRU: 40 is the video, 41 is the PowerPoint. I apologize.

BY MR. PETRU:

Q. You prepared this to help explain what you did, what the analysis is, fair?

A. Yes.

Q. Go to the next slide.

A. We talked about this earlier. Actually, if you can go back for a second. That image there, the black and white image is that very first tractogram. At the time just before we did it, we didn't even know if it was possible to make an image of one of those long white matter tracts. Once the data was in there, you pick a starting point, and it is a mathematical algorithm that actually tracks along and follows the neurotract, and it worked. And the one on the left is a modern tractogram that shows the internal structure of the brain.

Q. The left was the very first version, like V1?

A. Yeah.

Q. And the right is the contemporary version, how far it has come?

A. Yes.

Q. The first one was like the mathematical formula worked, eureka, we are able to track the nerve --

MR. BONVENTRE: Objection, your Honor.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MR. PETRU:

Q. Can you explain the second slide? We talked about that earlier -- It is self-explanatory.

What do we see in the third slide?

A. So this comes to this question: What is a concussion? Is this some highly technical definition? This is a paper from 1799 about a concussion.

A man fell from his horse in London, hit the back of his head, the doctor has been called, he finds the guy. He is vomiting. He is confused. He starts to get better later in the article, and then the patient dies.

The family allows the doctor to then do an autopsy and study the brain injury. And that's kind of how far this came along.

But the word "concussion," it is very general, you hit your head and there are symptoms. That hasn't changed very much. Now we can actually go in and see what exactly has been injured.

Q. Next slide.

A. And so this is a biomechanical analysis of the brain. Because now that we can see the injuries, we can see, wow, a person gets hit in the front of the head, certain places get damaged, other parts seem to come through without damage. And so this is part of a large number of studies being done that look at the way in which the brain deforms

and bends and twists when it is impacted, and why certain structures seem to get damaged more than others.

As we will see in this case, and very commonly, an impact in the front of the head results in the person being angry and irritable all the time. Why is that? So this helps us understand why that happens.

Q. Next slide.

A. In addition to just linear impacts, also rotational impacts, a twist or torque in the impact also is something that causes the brain to start to flow and swirl.

The brain has some internal dividers in it. One important one in this case is called the falx cerebri. It is sort of a leathery stiff membrane right down the center that partially divides the left and right side. And when the brain moves suddenly sideways or twists, the brain actually hits up against the edge of the stiff membrane, an extension of the skull, and causes some injuries.

Q. Next slide.

A. So this scan just -- to sort out the terms that we hear, this compares a head CT on the left, such as was developed, as I said, at our hospital in Wimbeldon in 1974. And the CT scan is the one where you go in now and it is fast, it is like seconds. It is more like a ring.

The brain MRIs, when you go in the big tube, usually it shows a lot more detail. You are in this scanner for

20 minutes while this complex image develops with lots of views.

The brain DTI image shown on the right side here is a more elaborate brain MRI. The colors -- for instance, if you look at the little green area pointing upwards, between the left and right side there is a subtle difference. One is a little thicker on the other side.

You really don't get that looking at the brain MRI of the same person. There is probably over one hundred times as much information stored in the image when a brain DTI is done. It is a very advanced MRI, and we bring out a lot of these details by the analysis.

Q. Dr. Filler, is it typical, even now when somebody is involved in an accident and they are getting triaged at the hospital, that the hospital would do a CT scan rather than a DTI initially?

A. Right. Because with the brain DTI, someone might be inside a tube scanner for 20, 30 minutes. And right after the head injury, they would rather get a quick image. And what the head CT is very good at is showing has there been a hemorrhage, is there blood, do we need to do surgery right now. It doesn't show subtle injuries that will affect thought processes and emotion over time.

Q. So it is appropriate in the ER just to see if there is some emergent situation that needs surgery, but not to

detect whether there is brain injury?

A. Yes, it is used for that emergent question, do we need to do something, do we need to do an operation to save the person's life or stop progression of the hemorrhage.

Q. In your experience, if you can, what percentage of people who do have MTBIs have normal CT scans or CT scans that are read by emergency room doctors as being normal, who actually do have a TBI that is not detected?

A. So people going to the emergency room with a head -- have hit their head, they might have had loss of consciousness. Even when -- we classify a mild traumatic brain injury, mild TBI, based on they didn't go in for -- go into a coma longer than hours. Maybe just out for a second, or not even a loss of consciousness at all.

So if you look at all those people who didn't have a coma, a lot of them do have hemorrhages, blood, they need surgery. Probably greater than 95 percent of people with concussions who will end up with long-term post-concussion symptoms, will have a normal CT when they first come in. There is no brain hemorrhage. All the injuries are in this tissue of the brain without any bleeding of the brain.

Q. What do we see here? This actually is from Emily Torjusen's scan, correct?

A. Yes. So this is a tractogram image looking from the right side, lateral view of Emily Torjusen's brain DTI image showing the tracts.

What you see here, the red arrow is pointing at an area that is abnormal. Further off to your left, you see those blue verticals reaching up. And in the back, green extensions reaching out towards the surface. And the very front, you see the green lines reaching out towards the surface.

But there is an area there, which the red arrow points to, where we don't see those extensions reaching up. That is a particular area when that happens -- I can explain it -- this is where you get this excess anger and irritability. And it is very common.

What has happened here in a head injury is that that part of the brain is particularly sensitive about being impacted against that dividing membrane, the falx cerebri, and you get this injury.

And it is a part of the brain that has what we call executive function. Here, for instance, the drive -- the emotion to anger comes up out of a deep part of the brain called the amygdala. It throws up into the frontal lobe. It is the frontal lobe's job to shut it down, no, suppress it, suppress it, okay, I am going to let some anger out.

When that gets injured, that person finds that

emotion is let out and they fail to suppress or control properly.

That area has two other functions, which when you think about it as an executive control area, it makes more sense. One of them is being able to multitask, which is allow different tasks to come to the surface of thought and to go back and forth between things. Another issue is being able to navigate from place to place. And these are just high-level executive functions, and control of emotions is one of them that happens to be centered at this location.

Q. The next slide is another image of Ms. Torjusen's brain?

A. Yes. Here the brain is positioned so the person is looking down. It is just because the right and left side are set up so that it will be in the standard medical fashion. The arrow tips are pointing to a green structure that is running from the top to the bottom of the image. And you will see it is thicker on your left side and thin on the right.

And this injury, which is also up against the falx cerebri there, a midline injury, just behind where we were looking at the other injury just a minute ago. When this is injured, it results in depression, anxiety and post-traumatic stress disorder.

So this is a mechanical location which, when you hit it, all of a sudden the person who didn't have a lot of anxiety, didn't have depression, didn't have PTSD, suddenly they have it because of an injury. And actually, interestingly enough, with some modern treatments, it is increasingly possible to repair it, and then the symptom goes away. So it's not because of, you know, something that happened early in your life, a family stress, whatever, emotional background, it's because of an injury that results in this depression, anxiety and post-traumatic stress disorder.

Q. How do you know -- how do you as a neuroscientist know that an injury to the supracallosal cingulum results in depression, anxiety and PTSD while an injury to the frontal lobe tracts results in increased anger, irritability and problems with multitasking? How do you correlate the consequence of an injury to a specific area to the radiology?

A. Well, this is -- this has been a fascinating thing in neuroscience. A lot of these things, the functions to different regions of the brain have been known for more than 200 years. So a classic -- the first one was this Dr. Broca, he had a number of patients that lost the ability to speak. They otherwise seemed to be fine, but they couldn't make any words. He had a number of them he

collected up who died and cut up their brains and found they all had this particular spot injured in the brain.

Another doctor found -- had collected up patients that could speak but couldn't understand anything said to them. And when they died, he cut up their brains -- this is in the 1800s -- and found a spot in the temporal lobe, which we call Wernicke's area. Others found connections between the two.

Bit by bit, over 200 years, we learned all the different functions of the brain -- many of the functions of the brain from injuries, people had an injury and then maybe died, like that 1799 case, and you could see what caused a symptom.

But then --- and so a lot was known about all this in 1990 when I was developing the technology. But this put it all in hyperspeed, because now every injured person -- we don't have to have people die and cut up the brain and find major injuries, we can study these. So that is why there are 150,000 research reports.

The government has spent billions funding thousands and thousands of studies. Not investigating if DTI works, but using DTI to study injuries of all types, so now we know with tremendous precision what each of these different parts of the brain do and what happens when they are injured.

So these are -- and when you look at it, when you talk about, for instance, 100,000 research studies, most of them involved 20 to 100 patients or 200 patients. So that 100,000 research studies involved studies on 10 million people. That's just the research. And then clinical use into 100,000,000 people. So this is a vast project of neuroscience in the world now that has led to this kind of understanding.

Q. Next image.

A. This is a blowup of that issue, the injury in Emily Torjusen to the left supracallosal cingulum that results in some emotional disorders.

Q. Next, you refer to an article here from Brain Injury.

A. This is one of many papers that deals with post-concussion syndrome. So with a concussion, a lot of people, the concussion clears up. A lot of them, it is that white matter, the lining that is rubbed off. It will grow back. And then over the course of a year -- sometimes faster, sometimes that long -- once the connection restores, once the lining is rebuilt, the nerve kicks back into normal function and people recover, and you can get a complete recovery.

Now, in that -- for instance, that can happen in 95 percent of people with a concussion by the time a year has gone by.

When we talk about post-concussive syndrome, so maybe you had a concussion and you were dazed and confused, and then a few weeks later you are all better. A football player goes back to play in high school, or you are out of school for a few weeks or off your job for a period of a month or two and you get better. But they don't all get better.

This is looking at the incidence of these post-concussive syndromes and the fact that DTI is very effective for identifying exactly the parts of the brain that have not repaired. Because when these parts repair the abnormality that you see on the DTI, it goes away, it becomes normal.

Q. Clinically, Dr. Filler, if Ms. Torjusen continues to have issues with depression, anxiety, PTSD, increased anger, irritability, and problems with multitasking, would that be consistent with a conclusion that those areas of the brain that were damaged in this train wreck still remain damaged to some degree?

A. Yes. And I have personal experience with hundreds and hundreds of patients. You know, it is not like a radiologist. I see the patients, I examine them, I talk to them. Usually our initial phone conversations -- whether it is now telemedicine or preferably in person -- take an hour or two. So I know hundreds and hundreds of

patients, and I know what their brain injuries look like, their patterns of recovery. This is what you would expect to see in someone like Emily Torjusen.

Q. Four and a half years after the incident, would it be consistent that the persistent symptoms indicate that she will have these problems to some degree for the rest of her life?

A. It is clear that once someone is a year out and has not recovered, there is a high probability they have a lasting injury. We also understand now that people can go on and progress to get worse with time --

MR. BONVENTRE: Objection, your Honor.

THE COURT: Overruled.

THE WITNESS: It is like we hear about CTE, or chronic traumatic encephalopathy, football players, Bennett Omalu, who I know, is a neuropathologist who made a lot of discoveries in that area.

So, yeah, they can persist, they can get worse, they can improve. DTI lets us get a window on that and also now shows us we have methods to treat and fix the ones that don't get better.

BY MR. PETRU:

Q. It doesn't mean that everyone who has long-term, four-and-a-half-year symptoms with brain injury will get better?

A. Right. We can help with some. It is a developing area.

Q. Next article here is the same issue, Persistent Post-Concussive Syndrome is Well Known to Result in FA DTI Abnormalities?

A. Right. This is showing -- this is part of that vast literature using DTI to study these persistent post-concussive syndromes, understands where the harms are. This is, you know, just a huge area of neuroscience.

Q. I am going to embarrass myself. FA DTI is fractional anisotropy?

A. Yes. This is one of the specific types of measurement that we do. So on the one hand, just like looking at a chest x-ray, you look at it and see, or a bone image, or you are looking at Ms. Torjusen's clavicle, we see a broken clavicle, we look at the tractogram and say, oh, this is narrow, this is interrupted.

We also have this ability to go in and select little tiny areas and measure this property called fractional anisotropy. What DTI is really doing is it is allowing us to see the direction in which neurons, the axons are traveling in every little voxel. A voxel is a three-dimensional pixel of the brain image.

It's a statement that if the FA is high, nearly 1.0, that all the little axons, thousands of them in a little

image voxel are all kind of headed in the same direction and seem to be pretty uniform.

The opposite would be zero, a voxel that has just like water in it, because the water is diffusing in all different directions.

We know for certain -- every different part of the brain -- what the typical measure, the typical directionality or uniform directionality should be. And so you can make these FA measurements, so these little small volumes that are probably the size of a pea or smaller that we measure. You can even do quite small, and can make a specific statement and say, well, the fractional anisotropy at this location is -- let's say it is .32. We know the typical average for this location is .56. The standard deviation, the amount of variability, and you come and say, well, on a statistically significant basis, the fractional anisotropy in, for instance, the hippocampus in this location is below what it should be in the normal.

You can say it is an abnormal fractional anisotropy. There it is. And the person has the symptom of impaired attention and memory formation that comes from a hippocampal injury. It is that level of detail, and FA is the measure of it.

Q. The next slide, you really talked about already, and

that is the DTI is standardized and used in many, many different applications. You talked about the number of articles, the scientific publications already. What do we see in this slide here?

A. That little red box marker there is showing an area where that -- the frontal lobe tracts are impaired.

Q. This isn't Emily?

A. Yeah, this is not Emily.

Q. The same with these, as well?

A. Right. This just shows -- some different views of where you see a narrowing of a tract, the top left of the A here, this is from an old paper from years ago, showing how a narrowing will be seen, the difference between the right and left side.

The LUF and RUF off to the left of the image, where one is narrowed out, and finding out, wow, that person has a functional deficit that matches that tract that helped us learn, yeah, these really show us where the injury is that causes these symptoms.

Q. Speaking of papers, I won't do -- your CV is thick. You have published many, many papers, books, book articles, appeared on multiple different programs explaining, teaching DTI, these processes over the last 30 years, correct?

A. Yes.

Q. The white matter issue, we kind of talked about this with the coup contrecoup?

A. This shows you can use different scanners with the same person and get different results showing what part is normal, abnormal. This is an example showing an ROI or region I have selected to measure.

This is an example, again, of small areas, regions of interest that we measure to assess for the presence of injury.

This is some of the internal tracts inside the brain that do specific tasks with emotion and memory formation we can see.

And this is kind of a report that is from -- this is Emily here, showing where we have a table on the right of a number of different locations that are measured. We have a numerical fractional anisotropy. We have a standard deviation -- a statistical term -- and if the measure is two standard deviations different from the normal, then we can say the part we measured is abnormal on a statistically significant basis, absolutely.

So it is a very quantitative, scientific way of using this image to measure and study all these tiny parts of a person's brain to understand exactly the injury. The tract is very nice. It gives you an overall picture.

And the other thing about this is -- the ROI is

looking at one spot. The way I like to explain --

Q. "ROI" is region of interest?

A. Region of interest.

What I like to explain about tracts is, for instance, let's say it is 1861 and you have a single telegraph wire from New York to San Francisco, and that's the only connection between the East and West Coast, and it is 99.999 percent perfect, but somewhere in Southern Wyoming, there is a little break in it about three millimeters, someone chopped it. Now there is no communication between the East and West Coast. It is out.

You might say, well, why focus on that one spot? I mean, 99.99 percent of this telegraph wire is perfect. Why do you focus on that little spot that is broken? Because that's the spot that shuts down the communication.

So the tractogram lets us see, because the algorithm is traveling along and hits a spot it can't get through, so then we can come and measure the ROI at that spot and say, yeah, that is the damaged spot, how did it get damaged? Let's follow that spot.

Q. Dr. Filler, I didn't see anywhere in your report anything to indicate that Emily Torjusen was damaged in the area of language, anything that would indicate that she couldn't write, anything that indicated that she couldn't learn or do well at school; is that accurate?

A. Right. She was fortunate to some degree in that her injuries were limited to certain parts of the brain. She didn't have any injuries that I could see in the speech function apparatus, and some of the major -- most of the major cognitive areas were intact or unaffected.

It was really this issue in the frontal lobe and in the supracallosal cingulum and the hippocampus, which she has been able to overcome some of it, but I think particularly the emotional component abnormalities continue to be a big problem.

Q. Would the fact that Ms. Torjusen has been able to graduate from the University of Washington with three majors, with a GPA -- in five years with a GPA of 3.6 or so indicate that she doesn't have brain damage?

A. Well, it indicates that her -- the critical intellectual capabilities for doing her schoolwork are intact or adequately recovered, but she still has injuries affecting emotional behavior primarily.

Q. So it is not an indication that she doesn't have brain injury, it is just an indication that those areas haven't been permanently affected?

A. Yes.

Q. We talked about the hippocampus, memory formation. All right. In your report -- first of all, when you did your report, did you have or rely on any outside source,

x-rays, CT scans, other than what you did through your services, Dr. Scovel's neuropsychological assessment, or were you looking at the films and just reporting what the films showed based on your study?

A. We had the referral from Dr. Spohr, a neurologist. She mentioned a number of the symptoms --

Q. Dr. Spohr? Dr. Spohr is the GP.

A. I'm sorry. Meghan Spohr, who had some description of some of the symptoms.

Q. But you didn't have the neuropsychological report?

A. No, I don't think so.

Q. Would the fact that the neuropsychological report in March of 2018, and your report in, I believe it was July of 2018, are similar in terms of their findings in terms of brain function, does that make sense to you?

MR. BONVENTRE: Objection, your Honor.

THE COURT: Overruled.

THE WITNESS: No. I think that these are both ways of evaluating a person. You know, these are objective, underlying facts, and two different physicians using two different methods are still going to find the same problem.

BY MR. PETRU:

Q. Same person, just looking at it in different ways?

A. Yes.

MR. PETRU: Thank you. Those are all the questions I have.

MR. BONVENTRE: May I proceed, your Honor?

THE COURT: Yes.

CROSS-EXAMINATION

BY MR. BONVENTRE:

Q. Good morning, Doctor.

A. Good morning.

Q. Doctor, I speak quickly from time to time. Tell me if I speak too quickly. All right, sir?

A. I will.

Q. Now, you just said that the patient was referred to you by Dr. Spohr; is that correct?

A. Yeah. There is a referral note from Dr. Spohr, yeah.

Q. Do you know whose idea it was for Ms. Torjusen to see you, Dr. Spohr's or someone else's?

A. Well, it certainly could have come from the attorney, because they were familiar that we did the advanced imaging.

Q. Doctor, you know that in fact it was Mr. Petru who referred the patient to you; isn't that correct?

A. I'm not sure. But if you say so.

Q. So as you sit here, you didn't know, when you first saw Ms. Torjusen, that she had a lawyer at the time? You didn't realize that?

A. Well, that's just the way our office works. I see the images and the clinical information. So I don't always see the referral detail.

Q. I have a question. Where did your office send the report to when you finished it?

A. We would have sent it to Dr. Spohr, and I think certainly it would have been sent to an attorney's office if they requested it, and the patient approved.

Q. This information that you provided is so important and vital and essential for the main doctor treating the plaintiff, I assume you would make sure that Dr. Spohr actually got a copy of this report, since it is so important, so vital, so informative? Did you make sure that Dr. Spohr got a copy of this report?

MR. PETRU: Objection, your Honor. Argumentative.

THE WITNESS: Yeah, so --

THE COURT: Overruled.

THE WITNESS: I mean, my office sends correspondence. I don't get involved in correspondence, so I don't know personally.

BY MR. BONVENTRE:

Q. As you sit here, do you know whether in fact Dr. Spohr got the report?

A. No, I don't.

Q. So you don't know if, for example, the main doctor treating the plaintiff didn't get the report for over two years, this very vital, important, essential report?

A. Right. I mean, we send it out to the -- as far as I now, it goes to the referring doctor. I don't know if there is a problem of, you know, them not receiving it.

Q. Well, when you called Dr. Spohr upon looking and issuing your report to talk to her about the report back in July of 2018, how did that discussion go?

A. I don't think I spoke with her.

Q. So let me get this straight. You did this report that is so important, so vital, so essential, you didn't immediately pick up the phone and call the internist who is primarily responsible for treating the patient; is that correct?

A. Well, what we usually do --

Q. Did you call up the doctor who is treating the patient immediately upon getting this vital, essential, important report?

A. No, I didn't call the doctor.

Q. And to this day, you have never spoken to Dr. Spohr, correct?

A. That's correct.

Q. And to this day, you have never spoken to anyone who is treating and seeing the patient, correct?

A. That's correct.
Q. The purpose of this report was not to help Ms. Torjusen, it was to help this lawsuit; isn't that correct?
A. No, the purpose is to help the patient. I can tell you --
Q. So could --
A. If I can answer --
Q. Could you tell me yes or no --
THE COURT: Just a moment.
MR. PETRU: Objection, your Honor.
THE COURT: You are talking over each other. Let him finish.
MR. BONVENTRE: Yes, sir.
THE WITNESS: As a neurosurgeon, I order images all the time for my patients. I will say I have never had a radiologist call me to tell me the details of the report. It's just not the standard.
BY MR. BONVENTRE:
Q. Let me repeat: The purpose of this report was to help in this lawsuit, it was not to help the patient; isn't that correct?
A. No. I mean, it is to help her get treatment.
Q. So what treatment did she get as a direct result of your report?

A. Well, as of 2018, there wasn't too much that could be done. We are trying to look and see the status. More recently, we have an array of treatments, particularly over the past few months, that have been developing. We are reaching out to patients to see if they have persistent symptoms.

Q. My question was: What, if anything, did any of the healthcare providers who actually have seen the plaintiff, what effect -- let me withdraw that. I have an even more basic question. How many times did you speak to Emily Torjusen?

A. I didn't have a direct call with her.

Q. When you say you "didn't have a direct call," is that another way of saying you never spoke to her?

A. That's right.

Q. So to this day, you have never spoken to Emily Torjusen to find out what her symptoms are, correct?

A. That's correct.

Q. And by the way, since you said that these things on this report repair -- can repair themselves, when you redid the report most recently, how did that go? How was the repair?

A. It had to be reimaged to look at the repair.

Q. How did the reimaging go? I'm sure you are here to tell us what exactly --

MR. PETRU: Objection, your Honor. Form of the question.

THE COURT: You need to be less argumentative.

MR. BONVENTRE: Yes, your Honor.

BY MR. BONVENTRE:

Q. How did the reimaging go?

MR. PETRU: Objection. Assumes facts.

THE WITNESS: I don't know. She could have been reimaged by another physician.

BY MR. BONVENTRE:

Q. Did you reimage her?

A. I did not.

Q. You don't know, as you sit here, you cannot advise the jury to what extent there has been repair and things that you were talking about, correct?

A. That's correct.

Q. Now, Dr. Filler, this is not the first time you have ever been in a courtroom, correct, sir?

A. That's correct.

Q. You have testified, I believe -- I read in some of your depositions, you have testified in excess of 600 times; is that correct?

A. I would say that is depositions over 25 years, yeah.

Q. 600 times? How many times?

A. In the courtroom, I would say it's about 60 or 80

over 25 years.

Q. So you have testified in a courtroom about 80 times; is that correct?

A. Yes.

Q. And you have testified in a deposition about 600, 700 times?

A. Yes.

Q. And you are also an attorney; is that correct?

A. Yes.

Q. You spend about what, 30, 35 percent of your time as an attorney?

A. No. I mean, 9:00 to 5:00, five-days-a-week, twelve-hours-a-day, six-days-a-week, I am a neurosurgeon. I mean, I do some work, you know, evenings or weekends. I am very busy clinically as a neurosurgeon basically.

Q. You are very busy testifying for lawyers, too, Doctor; isn't that correct?

A. Yeah. There is certainly something every month, a deposition; every few months, a trial.

Q. There is certainly more than every month or so, a deposition, if you have done about 800 of them?

A. Over 25 years, if you really think about it -- and that's pretty much evenly distributed. I didn't say 800. Whatever you saw, I might have said 500. And I think that's probably more accurate. A lot of it is just as a

treating physician. As a testifying expert, it is probably more like 150 over 25 years. When you look at that, you know, it is not -- perhaps it's the way you would like it to sound.

Q. You advertise to lawyers that you are available to testify, correct?

A. Yeah, I have an online notice that says we can do expert witness work in neurological imaging.

Q. You have multiple advertisements out for your services as an expert, correct?

A. I'm not sure about that. The only one I know of is a SEAK directory.

Q. In the SEAK one, it indicates right now that in the last four years alone, as an expert witness you have given 250 depositions; isn't that correct? Just the last four years alone, correct, sir?

A. That's probably correct, yeah.

Q. So the reality is, you have given a lot -- you have probably given close to a thousand depositions, if you have given just 250 in the past four years?

A. It has really accelerated. I didn't do much of this for many years. I have slowed it down quite a bit. When I was at UCLA in the '90s to early 2000, I was doing more of this, and then as we got busy, I did less and less. Probably over the last four years with all the interest in

DTI, there is an increased number of them, particularly over the pandemic period. It was very difficult to get surgeries in. Like Cedars-Sinai, for instance, pretty much closed the operating rooms for most of the year. So a lot more of the percentage of my time was spent with imaging patients.

Q. And you also give talks to lawyers and advise about your availability to testify, correct, sir?

A. Well, I have only once done a CLE talk. So mostly I talk at medical meetings. I don't know what you are speaking of.

Q. Did you testify under oath previously that you have given CLE talks to lawyers?

A. Yes, I did. It was part of a medical meeting, but we had a CLE session. I was the past president of the Society for Brain Mapping and Therapeutics. In our meeting in Miami about four years ago, we decided to offer both combined CME and CLE to -- so for both doctors and attorneys about DTI.

Q. Now, are you associated with something called the Texas Brain Institute?

A. Yes.

Q. And do you advertise on the website of the Texas Brain Institute that you are available as a subject matter expert for automobile accidents, slip and falls, sports

injuries?

A. Yes.

Q. And do you testify that you will provide, quote, compelling visual evidence; is that correct?

A. Yes. We do both defense and plaintiff work --

Q. Whoever is going to pay you, you will do it for, right?

A. It is more a matter of taking care of -- providing the information relevant to -- service. You know, that's a service that we are all obligated -- what doctors are supposed to do is help the courts and help juries understand the case. And the fact is that sometimes defense attorneys retain experts, sometimes plaintiff attorneys retain experts. Usually, both sides do. So I have a mix of those kinds of work.

Q. So this is just a service you are doing for the good of the court?

A. That's the idea is -- just as you are, sir.

Q. Well, let's talk about how much you are charging for this service for the good of the court that you are doing. How much did you charge for the test itself that was requested by counsel?

A. I would suspect that was probably in the range of 4 or $5,000.

Q. Well, do you have your billing records there, sir?

A. No, I don't.
Q. And you said for today, you are charging $15,000?
A. Yes.
Q. So we are up to about $20,000. And you took a plane. Do I understand you charge a thousand dollars every time you fly a plane for a lawyer?
A. No. We just charge whatever the cost of the flight is.
Q. Have you testified in multiple depositions that you charged $1,000 if you have to fly by plane and $1,500 if you have to go by car?
A. That's our fee schedule. That's the -- but we usually just bill the actual costs.
Q. So your fee schedule actually says if you have to go by car, it is $1,500, and if I go by plane, it is a thousand dollars, right?
A. Though we don't usually actually charge for car travel. It is more a matter of the time out of the office that is the issue.
Q. And did you ever meet with or speak with counsel?
A. I have spoken with counsel.
Q. And is that free or do you charge for that?
A. We usually bill for time spent, yeah.
Q. And your rate is $1,500 an hour?
A. No. I think -- for talking with an attorney, it

might be $500 an hour.

Q. Doctor, does your fee schedule say it is $1,500?

A. I would have to look at that. There might be different versions of it.

Q. All told, how much time did you spend speaking with counsel?

A. I would say less than an hour, I think.

Q. How much time did you spend on the PowerPoint? That's your PowerPoint, correct, sir?

A. Yes.

Q. Is that part of the visual services you provide?

A. Yes. A lot of it is stuff that is used, you know -- it is not particularly to do with Emily. So for an individual case, I will put the relevant images in. It might have been an hour or so.

Q. In fact, very few of those slides that were shown were actually Emily's, correct?

A. Right. The purpose is to explain the technology, as well as to show the critical findings, you know, for an individual patient, which I think that short slide presentation does.

Q. And you have a law firm, correct, sir?

A. Yes.

Q. And you actually advertise or indicate on your law firm website that you are also available for testifying as

an expert in personal injury lawsuits; is that correct?
A. Yes.
Q. You advertise on your medical websites and on your legal websites that you are available to testify for lawyers, like you are doing here today, correct?
A. Yes.
Q. So you have been doing this for -- since 1996, I believe? That's what you have testified to previously, correct, sir?
A. Right. I used to do expert witness testimony, as I say, when I was at UCLA. And then for years, it was pretty much what we call percipient, basically it was my patient. And then for the past five years or so, we resumed doing expert as well.
Q. And I believe you testified under oath previously that you have made millions of dollars testifying --
A. No, I absolutely have not said that. That is not true.
Q. You haven't made millions of dollars?
A. No. I mean -- no. Testifying? No.
Q. Let me get this straight. Have you testified under oath that for depositions, you have made -- testifying between 80 and $100,000 per year? That's your average? Have you said that under oath?
A. Well, when you say "made," essentially -- remember,

we could be losing money on that, because we might normally have been seeing and treating patients. There might have been a number of injections, ten patients being imaged.

I think what you are thinking of -- like if you have an academic doctor who has a salary, and if you pay him, he gets extra money. I am a solo practice, a doctor, with a number of employees, rents, equipment costs. Our normal income in a day might be $20,000, or $30,000, which is not coming to me, it is paying salaries, nurse practitioners, MR techs, rent, as I said, equipment maintenance.

I am on a pretty much fixed salary myself. So I don't get -- I must say certainly those are incomes into the medical practice.

Q. The companies that you own, your practice makes millions of dollars?

A. Well, "makes" usually implies profit.

Q. Doctor, I am --

A. You are talking about the billing for services that are paid for. I think overall our practice is not very profitable compared to most neurosurgical practices. Yes, we bill for the time. So we have income from those. I wouldn't say it is profits. You make it sound like I personally made millions, which is not true.

Q. I know, Doctor. It must be very tough living on

$15,000 a day testifying?

A. I don't live on that.

MR. PETRU: Objection, argumentative.

THE COURT: Sustained.

BY MR. BONVENTRE:

Q. Doctor, does your practice make millions and millions of dollars doing this kind of work?

A. In the sense that --

THE COURT: Please do not talk over each other. Doctor, that applies to you, as well.

BY MR. BONVENTRE:

Q. Doctor, there are neurosurgeons actually in Tacoma and in Seattle, Washington. Correct?

A. Yes.

Q. There are neurosurgeons a lot closer to where Emily Torjusen grew up, and where this courthouse is than you, correct?

A. Yes.

Q. Lots of them, correct?

A. Yes.

Q. And there is lots of neurosurgeons and neurologists and neuroradiologists in Washington and Oregon, another closer state, correct?

A. Yes.

Q. You flew up from Southern California, correct, sir?

A. Yes.

Q. Doctor, your testimony today was based on the images that you took of Ms. Torjusen, correct?

A. Yes.

Q. And you have not taken any additional images since back in 19 -- 2018, excuse me, 2018, correct, sir?

A. Correct.

Q. And since you haven't spoken with Ms. Torjusen, you don't know how she is currently doing, correct?

A. That's correct.

Q. And actually, since you have never spoken with Ms. Torjusen, you don't know how she is doing from her own words, correct?

A. That's correct.

Q. And you never looked at the medical records from her treating doctors, correct?

A. That's correct.

Q. Would you tell us all the things you have done? Did you tell this jury all of the things you have done to help Emily Torjusen?

A. Well, in this case we were asked to perform and interpret a DTI scan, which I did.

MR. BONVENTRE: I have nothing further. Thank you.

REDIRECT EXAMINATION

BY MR. PETRU:

Q. Dr. Filler, you have testified in other courtrooms, federal courtrooms, state courtrooms around the country, haven't you?

A. Yes.

Q. Have you ever had a vigorous cross-examination where not one question was asked of you about your findings?

A. Occasionally.

Q. This wasn't the first time an attorney asked you questions about getting paid and your services and other actions rather than what you did in this case?

A. That's correct.

Q. With regard to the other neurosurgeons, neuroradiologists in the Seattle and Tacoma area, could Amtrak -- if anything that you testified to, anything that you did with regard to Emily Torjusen's brain injury was inaccurate, could Amtrak have gotten a neuroradiologist?

MR. BONVENTRE: Objection.

BY MR. PETRU:

Q. Or neurosurgeon to do their own analysis to determine whether it is accurate?

THE COURT: Overruled.

THE WITNESS: Yes. Certainly, if they have something they are specifically concerned about on the

medical front, you know, substance, they will have an expert, and I will respond to any questions. I suspect they didn't have anybody who had any questions or objected to what our findings were.

BY MR. PETRU:

Q. And if Amtrak wanted to know what happened to Emily Torjusen's brain, they could have hired you to do the exact same thing you did in this case, and you could have explained to Amtrak, their lawyers, their claims representatives, exactly what happened to Emily Torjusen's brain, correct?

MR. BONVENTRE: Objection.

THE COURT: Overruled.

BY MR. PETRU:

Q. And they chose not to, correct?

A. Often we get defense requests like that, insurance companies ask us to see the patient and let them know, was there an injury, because if there is, we want to take care of the person. That often happens.

Q. Is that because traumatic brain injuries used to be referred to as the "hidden injury," and if you can't see it, you stick your head in the sand and pretend it doesn't exist?

MR. BONVENTRE: Objection.

THE COURT: Sustained.

BY MR. PETRU:

Q. Let me rephrase the question. Is DTI imaging important because we can now see what happens to somebody's brain when they have a TBI, and before you couldn't?

MR. BONVENTRE: Objection. Leading.

THE COURT: Overruled.

THE WITNESS: So in medicine, you know, we like to be able to see exactly what is wrong so we can best target treatments. In law, there is an interest of the court in just trying to say did an injury occur. So I think the report placed those roles of showing, well, here is the injuries, now we can understand the objective facts.

BY MR. PETRU:

Q. Let me back up just a little bit. As a neurosurgeon and neuroradiologist, when you are asked to interpret a DTI, such as Emily Torjusen's, did you do the exact same thing in this case you do in every other situation, whether it is a lawsuit, whether it is another doctor asking you to do a DTI, was it the exact same process?

A. Yeah, the process is the same.

Q. And had Amtrak wanted to know, they could have asked you directly?

A. Yes.

MR. PETRU: Thank you. That's all the questions I have.

RECROSS-EXAMINATION

BY MR. BONVENTRE:

Q. I have a few questions. You just told the jury that the purpose of this test is so the doctor can, quote, best target treatment for the patient. Can you tell me all the things you did to ensure that the doctors who were treating her had this report so they can best target the treatment? Tell us all the things you did.

MR. PETRU: Your Honor, beyond the scope. Asked and answered.

THE COURT: Overruled.

THE WITNESS: Generally, in medicine an imaging physician -- this is my role in this case -- prepares a report, and the report can become the basis for treatment. The fact is, in head injuries, until very recently, literally in the past few months, we really didn't have repairs for this type of thing. So now we are in the process of going back over time to reach out to people.

But the important thing was to show what is the injury. And we certainly encourage seeing and doing follow-ups with patients, we encourage follow-up imaging. I think those are all helpful. But I don't necessarily control, you know, all of the interactions of the patients

and physicians. But usually the imaging is an important step.

BY MR. BONVENTRE:

Q. Well, Doctor, your report said Dr. Spohr referred you. And your office didn't even send a copy of the report to Dr. Spohr --

MR. PETRU: Beyond the scope, your Honor.

MR. BONVENTRE: Withdrawn. No further questions.

MR. PETRU: Nothing further, your Honor.

THE COURT: Thank you. You may be excused.

We will take our morning recess at this time. Please do not discuss the case and we will resume in 15 minutes.

(At this time, the jury exited the courtroom.)

THE COURT: I want to say something about leading questions, especially when they are experts. It is actually helpful to the jury for a lawyer in laying foundation to ask questions that are technically leading. I don't like leading questions that go to ultimate issues, and I will sustain those. I recognize that I am not always consistent. But if the question basically could say was the light red or not as opposed to was the light red is not particularly important to me.

I will try to, as the trial goes along -- and I believe I mentioned this at the pretrial conference, I usually do, but I may not have.

MR. BONVENTRE: Your Honor, you actually mentioned it in regards to trial as well. I try not to object a lot, Judge. I was objecting to mainly what I viewed as summarizing testimony. I understand what the Court's position is, and I appreciate it, Judge. Thank you.

THE COURT: The other thing is I would like you, Mr. Bonventre, to stay a little closer to the podium. I am not going to require you to stand entirely behind it, but a little bit closer would be appreciated.

We will be back in 15 minutes.

(Recessed.)

THE COURT: I think we are successful in getting the Zoom connection. That's going to be your next witness. We can bring in the jury; is that right?

MR. PETRU: Yes. Since we are on record, I want to thank the IT department for doing a great job.

THE COURT: They do a great job. We have been through two years of COVID and had a lot of virtual trials. Now, we are sort of hybrid. It is a new challenge.

MR. PETRU: We have been using, off the iPhones, FaceTime for years for witnesses too far to travel. It plugs into the system and works pretty well.

THE COURT: We did, too, pre-COVID. We changed

our platform over to Zoom. Let's bring in the jury.

THE CLERK: Mr. Crossen, can you hear the Judge?

THE WITNESS: Yes, I can, just fine.

THE CLERK: Great. Thank you.

(The following occurred in the presence of the jury.)

THE COURT: Everyone, please be seated. You are going to call your next witness.

MR. PETRU: Yes, your Honor. At this time, I would like to call Dr. John Crossen to the virtual stand.

THE COURT: All right. You should be able to see him on the screen. Also, we have here to usher this through Tony Duck, who is our guru from IT, as we have been doing a lot of virtual testimony and even full trials until the COVID numbers were reduced to the point where we could resume having in-person jury trials, as we are doing here.

So, sir, if you would raise your right hand, please, the oath of witness will be administered.

JOHN CROSSEN,

having been sworn under oath, testified as follows:

THE COURT: All right. Jurors, you are all viewing correctly? I see everyone nodding. You may proceed.

DIRECT EXAMINATION

BY MR. PETRU:

Q. Good morning, Dr. Crossen.

A. Good morning.

Q. Would you please share with the jury what you do for a living?

A. I'm a licensed psychologist, and I do therapy with individuals and couples, and I do evaluations for people that are referred to me for evaluation.

Q. In this case, with regard to Ms. Torjusen, I understand you saw her and evaluated her initially in August 2018; is that correct?

A. That's correct.

Q. And administered a number of psychological tests, and followed that up with several therapeutic visits, correct?

A. That's right. Five therapy visits with her.

Q. And then you saw her again in 2021, and essentially repeated the evaluation that you had done in 2018, correct?

A. That's correct.

Q. In 2018, when you saw her initially -- first of all, where is your practice?

A. It's in Portland, Oregon.

Q. In 2018 when you saw her initially, a recollection is that she was looking for a therapist and we found you and

asked you to visit with her and see whether you would take her case, correct?

A. That's correct.

Q. And prior to that time, you and I or anybody at my firm, we didn't know you, had never worked with you; in fact, we didn't even see you until after the evaluation and the work was done initially, correct?

A. That's correct.

Q. Can you share with the jury your educational background?

A. Yes. I have a Ph.D. in psychology from the University of New Mexico. My specialization was in clinical psychology. My minor, or should I say areas of emphasis were in neurobiology and learning and memory.

Q. What is neurobiology?

A. The relationship of the central nervous system to behavior.

Q. In addition to your Ph.D. from New Mexico in 1985, you have a master's from Western Michigan in 1975, correct?

A. Correct. I worked in the lab for my master's area doing research on operating conditioning and classical conditioning, and my master's thesis was involving analyzing ways that various strong tendencies of behavior could be disrupted with the signal of a reward that was

previously given when a light signal would come on. I researched the interplay of classical conditioning, which is also known as the Pavlovian conditioning, to the general public and operant conditioning, which is the reinforcement paradigm that is known to the general public.

Q. Neurobiologically, how does that equate to, for example, work with adults in psychology, work that you do now?

A. It really helped me understand that you can help people -- well, not people, but the theory is that -- because I only worked in the laboratory with animals, but the extension would be some curiosity about how to remain positive with people in order to get them to slow down what they are doing and pay attention to something else.

Q. After you got your Ph.D. from New Mexico in 1985, you came back to Oregon -- you came to Oregon where you were a resident and eventually chief resident on the medical -- in medical psychology at OHSU, correct?

A. That's correct. I did an internship here, and then I did two years as the chief resident. And then I went on to being appointed to the faculty and the medical staff. And I remained there until I retired from there in 2016. During that time, I was also appointed to the medical staff at the VA in Portland, and participated in some

research and clinical activities there for probably close to ten years, until retirement again. And I still remain on -- they call it the clinical staff at Oregon Health and Science University, and work with the family residents -- the family medicine residency program conducting groups to help the doctors develop more empathy for their patients and to understand their own reactions to their patients.

Q. While working with the VA, did you have frequent and regular involvement with patients who had PTSD or traumatic brain injuries, or both?

A. Both, yes.

Q. During your years through OHSU, did you have involvement with evaluating and treating students?

A. Yes, I did. I developed a relationship during my residency and faculty years with the student health service. They hired me to work there in about, if memory serves me right, 1999. Right around there, 2000. And I eventually became the head of the behavioral service program for the student health service at OHSU, where we serve medical students, graduate students, undergraduate students in some specialty areas of health services and so forth.

Q. As the head of student health services with medical students and other folks, did you periodically treat -- evaluate and treat students who had problems associated

with TBI or PTSD who nonetheless were able to continue being students?

A. Yes.

Q. Does the fact that somebody can be a student and do well academically indicate that they do not have problems with PTSD or TBI?

A. Not at all.

Q. What do you mean "not at all"?

A. PTSD is something, TBI is something that intrudes on people's lives no matter what they are doing. These kind of things -- disorders -- mental disorders occur in the course of everyday life, and everyday life can involve working, it can involve going to school, and people are able sometimes to continue doing those things and sometimes not.

Q. Can they continue doing those things and excel and still have problems with TBI or PTSD?

A. Absolutely. I have had long experience doing that kind of rehabilitation work. While I was at Oregon Health and Science University, I was invited to participate for about ten years with the community reentry service of the Legacy Health System. It was a part of their rehabilitation program for brain injury that focused on helping people make that last transition into everyday life after being in the hospital and being in treatment

programs and outpatient services, and helping them to make that transition into everyday life with whatever deficits they might have been having and helping them to develop strategies to work with those deficits as successfully as possible, and resume what areas of life they could resume in a normal way, being parents, being wives, being husbands, being workers and so forth.

Q. What is your normal and customary standard practice, if you will, when you encounter a patient for the first time? Do you go through a normal protocol?

A. Yes. Depending on what they would present with, the problem they had, I would have a focus on either doing a personality assessment -- we would focus on their personality and social functioning. Interviewing is always a core part of it. Getting information about their childhood, their adult history, getting some information about their health history, and information about the onset of the problem that they had and at the time their assessment, and developing a protocol of tests to zero in in an objective way to measure their distress and their functioning and their abilities. And that is very relevant to the assessment question.

Q. In your reports, I will just go through the list of headlines, if you will. In both reports you at first just have identification, Emily Torjusen, her birthday, service

date when you saw her, a blurb about why she was there, and then a section showing the evaluation procedures of the tests that you employed to evaluate her, a section called "history of presenting problem," a section called "background information," a section called "health history," a section called "behavioral observations," a section called "review of medical records," and then in the first report, at least, you went to the individual tests that you administered, discussed the results of those tests, and ended up with your summary, impression and recommendations, correct?

A. That's correct.

Q. Can you share, without reading the whole thing, the salient points that you got from the history of the presenting problem when you saw her in 2018?

A. The problem, as she presented, was that she was on the inaugural run of the Amtrak route heading south from Washington to Oregon, and that she was with a friend, and that there was a crash, and that she was rescued from that crash. And as time went on, what she said is that she really believed her personality came through the worst, and she felt she was changed forever.

She acknowledged that she didn't control her anger very well, that she would be impulsive and talking without -- couldn't restrain herself or modulate her

emotions around friends, and people were noticing this.

She said that she was impatient, found it difficult to be nice to people, was rude and couldn't make herself behave conventionally in a calm way.

She knows that she had problems in tense situations, that her behavior would escalate in negative ways. She felt that she -- relationships with other people were affected adversely. She said it shook her whole faith in human beings. She lost all faith in God and couldn't imagine if there was any reason to believe anything anymore.

Q. I'm sorry. If I can ask you a favor. The microphone that you have there is very sensitive, and we can hear the papers shuffle.

A. Sorry. Thank you.

Q. Sure. I interrupted you. But let me ask this: Based on your original initial interview with her, did you determine that you should use some test modalities to help evaluate her?

A. Yes, I did. It seemed to me from the things she was presenting and from the history that she had, that it was very likely that she might have PTSD, which is called post-traumatic stress disorder. So in planning to do therapy with her, I administered several tests that would help me see --

Q. I'm sorry. Excuse me. You determined that you needed to administer several tests. I put on the screen here from your initial report the evaluation procedures, the tests that you would use. To put them on the record, it was clinical interviewing, review of medical records, which is the discussion -- and I believe you had Dr. Scovel's neuropsychological report --

A. Yes.

Q. And then you administered six tests: the symptom checklist revised, the SCL; the structured inventory of malingered symptoms, or SIMS; the trauma symptom inventory revised, the TSI; the Novaco anger scale and provocation inventory, or the NAS-PI; the trauma recovery scale; and the aversive childhood experiences scale, correct?

A. Correct.

Q. And when you saw her again in 2021, did you utilize the same tests to evaluate her three years later?

A. Yes. The idea was that she was interested in resuming therapy. And so it seemed most appropriate during the passage of that time how she might be the same and how she might be different, and the problems that she -- challenges that she was facing. So I used the same protocol.

Q. I probably will -- let me just get this out of the way. When you evaluated her in 2018, when you evaluated

her in 2021, when you saw her in the half dozen or so sessions in the fall of 2018, were all of the conclusions and your opinions based on a reasonable degree of psychological certainty?

A. Yes.

Q. And will all of the opinions you express today similarly be on a reasonable degree of psychological probability?

A. Yes.

Q. What I would like to go through are the tests or the evaluations -- the tools that you used, and have you share with the jury what you found in 2018, and then share with the jury what you found in 2021. Okay?

A. I will go through them test by test in order. Would that make sense?

Q. Yeah. I might even ask a question once in a while. That's my job. We will start with the SCL90 in 2018. First of all, what is the SLC, what does it do?

A. It's a measure that has been developed and researched for well over 35 or 40 years. The R stands for the revision, because it was reformed. It is 90 items. That's why it's called the SCL90. The "SCL" stands for symptom checklist. So it is the symptom checklist of 90 items revised.

And it covers various common presenting problems

involving health concerns, involving difficulties with concentrating and thinking, anxiety, all kinds of anxiety, generalized and phobic anxiety, depression, mistrust of other people. Covers social isolation problems, and also problems with extreme concerns about mental and physical well-being.

So it is a broad screen test that has less than 100 items, that is useful for getting a sense of what kind of problems a person might have, groups of problems so you can look within that group of depression and see what symptoms might be the most troublesome for them. And that is true for all of the scales on the SCL90R.

Q. What did you find based on your evaluation of the results on the SLC90 in 2018, relative to Emily Torjusen?

A. Well, compared to women in the population at large, which would be called the normative comparison group, her distress about severe mental and physical problems, about problems with concentrating and focusing her attention and maintaining it, her problems with being overly sensitive in relationships, and her problems with trust in relationships were all higher than 98 out of 100 people in that normative group -- women in that normative group.

Q. As a psychologist, what does that mean to you?

A. That means it is an extreme problem. Higher than 98 out of 100 we call the 98th percentile. So of all -- if

there was 1,000 people in that group, she would have been higher than 980 of them in relating her distress.

Q. Is that --

A. It would be 98 out of 100.

Q. Is that an indication of extreme or very high distress?

A. Definitely. And on the other scales, all of the other scales were higher than the 85th percentile. So higher than 85 out of 100. I used the 85th percentile, roughly, as a way of saying, when we measure this it is higher than two standard deviations beyond what is normal. And that's a technical way of measuring on the tests that we use, whether it is IQ tests or personality tests. We start with saying where is this person in relation to the average.

And when you are at the 85th percentile, you are really high. You are higher than 85 out of 100. When you are at the 98th percentile, you are even higher than that. The scores for being high are set at the 85th percentile, and really extreme at the 98th percentile.

Q. In 2021 you readministered the SLC90, correct?

A. Correct.

Q. And what were the results in 2021?

A. Well, she still had very high distress, but it was a little bit different then. What was the same was her

problems with concentrating, keeping her attention focused were still at the 98th percentile. Also noted was her anger management problems were higher, at the 98th percentile. Previously, they had only been at the 85th. I shouldn't say "only," they were at the 85th, which is high.

Q. So the disinhibition or anger management, that became more problematic with time, particularly compared with some of the other modalities -- with some of the other areas?

A. Yes. It became worse. It went from being bad to worse.

Q. Have you seen that before in patients who have both PTSD and TBIs?

A. It is common to see changes over time, and especially over time when people's lives change, because as we spoke about at the beginning of my testimony, traumatic events occur at a certain point in a person's life. We think of the trauma as being what happens inside the person after an event occurs. So the train wreck was the event. We think of the trauma as being what is inside the person, and that can change over time as a person faces new challenges in life.

It is especially common with young people who are in either the adolescent or post-adolescent phase and are

building a life for themselves. They find that life doesn't really get easier as you get older, that life gets more challenging, and the trauma is still there interfering with meeting those challenges.

It is kind of like trying to rebuild your airplane while you are flying it. If you can think of a metaphor for a human being, trying to build their life and adapt to how they are living it when you are trying to behave differently than they were before, dealing with this difficulty.

Q. I'm sorry. So one of the salient features that I hear you testifying to is that not only is the consequence of a brain injury and the traumatic event important, but the fact that Emily was just 20 years old when she suffered these insults affects her formatively and can have a greater significance because of where she is developmentally?

MR. BONVENTRE: Objection.

THE COURT: Sustained.

BY MR. PETRU:

Q. I have to re-ask the question. The fact that she is 20 years old, does that have a significance in terms of the potential affect of brain injury and PTSD when the traumatic event occurs?

A. Yes.

Q. Any other observations in 2021 with regard to the SLC90?

A. Yes. The depression scale was also higher than it had been. It was at the 98th percentile, which is an increase from where it was previously, around the 85th percentile or so. Also, the concern with her physical well-being, with general anxiety symptoms, and with mistrust was still high. It was still at the 85th percentile, well beyond what we would consider the normal range. We would consider the normal range to be less than the 85th percentile, approximately.

Q. And any other noteworthy observations in 2021 on the SLC90?

A. No. I think that covers it, in terms of the groups of symptoms was very high.

Q. The next -- at least in my notes, the next area that you tested in 2018 was the SIMS. What does the SIMS do, and what was the result in 2018 on the SIMS?

A. The SIMS is a way of measuring complaints people have about their lives, in other words, their symptoms they are endorsing. Sometimes people -- what they did to establish what is normal was study people who had various disorders. Those would include various neurological impairments, depression, problems -- let me think of some of the other ones that we see on there. Excuse me for a second. I

don't want to rattle the papers here. Language impairments, psychotic problems, problems with memory. We have ways to see what people in those groups generally would say they endorsed, and items they just didn't endorse as much. And so the SIMS is designed to say how unusual are the symptoms someone is endorsing compared to people in these various groups.

Q. If I understand it, rather than the SLC, which compares to all women as a norm, now you are comparing Ms. Torjusen's symptomology and the impact of the symptoms compared to other people who have PTSD or TBIs or other psychological problems associated with trauma, fair?

A. Well, we don't have a comparison group for PTSD. So that's part of my interpretive judgment as a psychologist is to say how might this look, what do we know about PTSD, and what do we know about this SIMS test that will help us look at her problems. And also we do have the measures of what people show when they have memory disorders and neurologic impairments.

So it was close enough for me to say this is one of the better measures available for someone that has her kinds of problems and we'll see how unusual -- how many unusual items she endorses versus people that don't have these problems.

Q. What was the result of the SIMS exam?

A. About 17 problems, which is higher than the cutoff score of 14. Largely that was due to her having more in the area of neurologic impairment and more in the area of memory impairment. Her scores in those areas were five, and the cutoff score was about two.

So what we are instructed to do in using this test is to look at the items that they endorse and see if we can understand better why these atypical items might have been endorsed. In her case, it seemed pretty clear that she was having problems with her mood, problems with her feelings, not being able to express them very well, and problems with sleep and low energy, and some problems with eating, appetite.

These to me didn't seem like they were flagrantly bizarre symptoms. They seemed to be meaningful given her history. I was able to say she does have some extreme problems. We already knew that from the SCL90. And on the SIMS we could see, yeah, they are extreme. She is really saying that she has a lot of these problems that maybe most people that have these problems with memory or neurologic impairments don't complain about. It was a signal to me that these were probably still very acute problems for her. She is in the four months after the injury stage, and in comparison to the normative groups where they had well-established diagnoses for

long-standing disorders, she was probably still adjusting to the trauma that was within her, that was activating all these symptoms.

Q. Just to clarify, you saw her eight months after the injury. The injury was in December of 2017?

A. I'm sorry. That's correct. Yeah.

Q. As a result, did you conclude that the symptoms that she was experiencing, her expression of the symptoms were genuine, legitimate?

A. Yes. That the extreme distress she was experiencing was a legitimate distress, not a fake distress.

Q. In 2021, you also administered the SIMS. What was your conclusion from 2021?

A. In 2021, she no longer exceeded the cutoff scores -- her overall cutoff score. But in one area she did, and that was in the memory area. The cutoff score is two, and her score was three. You know, I think that was something that I -- she was highly aware of, highly bothered by it, and it did not seem to me that it was a sign of faking anything.

Q. Did you ever get the impression that Emily Torjusen ever faked anything?

A. No. When we talk about faking, we are talking about malingering, where someone is presenting themselves in a different way than they really are in order to get

something. That never seemed to be warranted based on the assessment that I did and the information I had. And I usually get this information whenever I do an assessment of someone with PTSD. In her case, I could say this is not somebody that is malingering, this is real distress.

Q. The next test was the NAS-PI, NAS-PI. What was that and what were the results?

A. It is called the Novaco anger scale. Novaco is the author of that anger scale. He is still active as a clinician and a researcher. The NAS stands for Novaco anger scale. The PI is an addition to that scale that he put in when he revised it. The original thing was developed about 40 years ago, and the PI was added I think about 25 years ago. PI stands for provocation inventory. And that's an additional part of the test he put on there to see what kinds of situations might be the ones that would be most problematic in this anger management problem for an individual.

Q. What was the result of the NAS-PI in 2018?

A. Her total score was higher than the 98th percentile. We talked about what that 98th percentile means. Also, her score was considered valid. It has an internal validity way of looking at problems. "Valid" means that the test is measuring what it is intended to measure, that it is not measuring something like an exaggeration or a

misunderstanding of the items or something like that. It's a way of -- when we talk about validity, we mean in everyday language that the test is measuring what we intended to measure.

Her results are that the anger overall was -- when you consider all the dimensions of it, was above the 98th percentile. In particular, the areas of the cognitive part of anger where you get ruminating and you get madder and madder in your mind as you think about it more and more, that was higher than 98th percentile. And also the physical arousal, the sense of emotion of just getting overwhelmed, was also at the 98th percentile. Both of them are very high.

Q. Would that be consistent with reports of Emily finding herself on a bus or a plane and just crying just out of nowhere? Would that be consistent with those findings?

MR. BONVENTRE: Objection.

THE COURT: Overruled.

BY MR. PETRU:

Q. You can answer.

A. I didn't hear. Should I answer that?

Q. Yes.

A. Yes, it would be consistent with that.

Q. And then you retested her in 2021 on the NAS-PI.

Were the results the same or different than 2018?

A. They were a little different. Her total score was still at the 98th percentile. The cognitive score, where we talk about somebody ruminating and getting more and more upset when they think about it, was less. It was at the 86th percentile. It was still above what we consider normal, but not as extreme as it had been. Her arousal level, the sense of just feeling physically and emotionally overwhelmed, was still at the 96th percentile, so very short -- very close to 98.

And there was another dimension that had been lower before. It was the behavioral dimension, which means acting out the anger, not just feeling it, but how you behave, and that had risen to the 95th percentile. There was strong indications that managing her anger in the second evaluation was even more problematic for her than it had been in the three years previously.

Q. Would that also be consistent with findings of disinhibition, disregulation?

A. Yes, exactly.

Q. The next test is the ACE, which is the --

A. I'm sorry. Are you able to see me?

Q. Yes.

A. My screen went blank there. I'm not sure why that is.

Q. The next is the aversive childhood experiences scale, the ACE. Did you find anything above the scale in the ACE?

A. No. The ACE is a measure of childhood trauma. A large study by the Kaiser foundation was shown to be predictive of subsequent physical health and mental health problems if the score was higher than the cutoff. And the cutoff score is four. Her score was three. So there is a degree of vulnerability there, but not an extreme vulnerability.

Q. That degree of vulnerability, might that make her more susceptible to the ill effects of TBI and PTSD than somebody who might have been in a two, for example?

A. Well, if it was four or higher, I would definitely say yes. It's three, so it is kind of a borderline score. It would be clinically, in treating her, not very wise to ignore that and say she is a person with a score of zero. It is closer to four than it is to zero. So I think there is a moderate degree of vulnerability there compared to the normal population of women.

Q. And people who are more vulnerable -- will people who are more vulnerable or potentially more vulnerable have a worse outcome or potentially have a worse outcome with PTSD or TBI than someone who is less vulnerable? In other words, is vulnerability a factor in how severe the damage

is from the trauma?

A. It definitely is shown to be that way for PTSD, and the research studies that are foundational for the diagnosis in the American Mental Health System I would imagine the same thing would be true for TBI.

MR. BONVENTRE: Objection.

THE COURT: Basis?

MR. BONVENTRE: "I imagine."

THE COURT: Overruled.

THE WITNESS: That would be my judgment. And I would say that would be to a reasonable degree of medical or psychological probability. I would base that -- my opinion -- I am a Fellow of the National Academy of Clinical Neuropsychology, which recognizes my competence in research in clinical work with brain injury situations. I think I would have -- I think -- I just want to bring that credential into the open so I am speaking from a point of having specialty skills in this area.

BY MR. PETRU:

Q. Thank you, Dr. Crossen, for the enlightenment.

The TSI is the next test that you administered to Ms. Torjusen. The TSI is the trauma symptom inventory revised. I just blew that. No, I didn't blow that. What did you find on the TSI?

A. The TSI is really specifically designed to consider

dimensions of PTSD. Her initial scores were elevated to a fairly extreme level in several areas. Her general health concerns were at the 96th percentile. Her reported behaviors that would be in the range of what is called sexual dysfunction were at the 90th percentile. Her lack of self-awareness and seeing herself fully and accurately was at the 95th percentile. That's something that we see often in traumatic -- in post-traumatic stress disorder, where people have a narrow focus, looking quite a bit at their problems and deficits and seeing themselves as sometimes even to the point of being worthless.

She also reported that she was very anxious. And so that was at the 87th percentile, again above normal. She had many intrusive experiences, which means things popping into her mind that she didn't want, that were unwelcome, and now she is thinking about something she doesn't want to be thinking about, and she can't get rid of it, and that's a very big problem with people with PTSD.

Q. Okay. You got there. So intrusive thoughts, daytime intrusive thoughts, nocturnal images, such as nightmares, are those hallmarks of PTSD?

A. Yes, they are.

Q. And does she suffer from them?

A. She was at the 86th percentile in 2018, and she continued to have problems with that ongoing. They were

not quite as severe in 2021.

But the other thing that was severe, above normal, two areas in 2018, were tension reduction behaviors, just things that you do to calm yourself down because you just find yourself tense all the time. There are a variety of things that people do that way. I think an example would be chewing your fingernails or trying to get out of a situation, or changing the subject, or various things to just try to reduce the tension that is building up.

And then her anger problem was at the 85th percentile measured on the TSI. So that's a different measurement set of items than the other tests. But we are seeing anger as above normal in multiple tests with her in 2018, on the SCL90, the NAS-PI, and on the TRS, and the TSI-2, so some of these are validating across different measures, which is something we do when we give multiple tests to see is this just, you know, an artifact of the way the words were -- the patterns were presented and worded on one test, or is this something that is going to be seen as different. Researchers and clinicians create tests to measure different parts of psychological functioning.

Q. All of which point to and support your endorsement of a diagnosis of PTSD in 2018, and again in 2021, correct?

A. Correct, yes.

Q. Excuse me. The TRS -- TRS, trauma recovery scale, I

think it is --

A. Yes.

Q. What is the trauma recovery scale, how does she do in 2018, how does she do in 2021?

A. It's a scale that has ten items on it. They are measured on a rating scale of one to ten. These are items that relate to how someone is dealing with the trauma that is inside them as they are trying to recover from the events that happened that caused this within them. And her problems were very, very difficult for her in 2018 in several areas.

In these areas her rating -- her ability to deal effectively with these things was rated zero to one, about as low as it could be for nightmares or avoidance of situations, or having supportive relationships, or being able to deal with spontaneity in situations without needing to control the whole thing, or concentration problems, and for hope. She was just about hopeless at that point that she could manage this kind of thing that was going on in her.

Her overall score was quite low. It was about 45, I guess.

Q. What does that mean?

A. Well, it's really low. I think if you are below 70, I think it is considered to be very problematic. And 70

is already something where you would say, gee, if you are not at ten for hopefulness and feeling safe and being able to be spontaneous, boy, what's up with that? What's the difficulty? I would imagine -- we don't have norms for people on this that are as extensive as like the SCL90. But if someone was in the 70 range, I certainly would say they would be a candidate for therapy.

Q. In 2021, what did you find on the TRS?

A. It was still at 45. The items that were problematic for her were a little bit different. Her need to control the environment was still very intense, at the level of zero. Her problems with concentration were still very difficult, and they were rated at one. The avoidance problems were still extremely difficult. They were rated at two. The problems with recognizing, you know, her own distress and actually controlling her own memories about it were still problematic at the level of three. So overall score was 45 again, an overall score showing a lot of difficulty recovering from the trauma that was within her.

Q. Do you believe that Ms. Torjusen could benefit from psychotherapy?

A. Well, that was the conclusion that I came to when I evaluated her in 2021 and talked with her about that. I would recommend that. I knew she had some experiences

trying it and it didn't go well. I asked her what didn't seem to go well, and she explained that. I said, you know, I think that might be somebody that really wasn't used to working with people that had trauma. By looking for a therapist that would be what we call trauma informed, she would have -- she would find better rapport and feel better understood and heard so that she could feel safe enough to do things we need to do to cope effectively with PTSD.

Q. Dr. Crossen, in your -- I didn't do the math, but in 20, 30 years of evaluating and treating students and veterans and other folks who have PTSD and brain injury, and have some semblance of physical injury, have you found that there is a recalcitrance or reluctance or difficulty that such patients have in getting or following through with therapy?

A. Absolutely. This is very -- I would say more common than not, if I was going to look at all the different problems, those would be two, PTSD and brain injury, where there is a reluctance to deal with the problems through therapy, where I would say in my experience the most common disorders where you see that.

Q. So more frequently than not people have difficulty with therapy and don't follow through with the therapy because of the myriad of problems they have; is that fair?

A. That is fair to say. That is my experience, yes.
Q. Demonstrative exhibit, Exhibit 39, if the magic works.
THE COURT: Is there any objection to this demonstrative exhibit?
MR. BONVENTRE: No objection.
THE COURT: It may be published.
BY MR. PETRU:
Q. Dr. Crossen, what do we see here?
A. Well, it's a visual way of presenting a theory of how people are affected by problems that they might have that are psychological.
Q. In the middle there is the cognitive. That would be brain function, emotional, which would be PTSD, anxiety, depression; physical would be physical injuries, fair?
A. Correct. Actually, I was going to say this actually would be something useful for considering even medical problems that weren't psychological problems, because the point of this diagram, the heart of it, where you see the overlapping circles, is that a human being is going to be affected by how their body feels to them, by how their thought process is working for them, and by how they are managing their feelings, and these things relate. You can often under stress have a headache. That would be that overlap between emotional and physical. You can sometimes

have an overlap between emotional and cognitive when you are depressed and you are thinking about all the things that are wrong in your life. You can even have, in more severe cases of depression or anxiety, you can have a change in physical functioning where sleep can be affected or avoidance happens and people physically don't go certain places or do certain things because of their overwhelming emotion and cognitive difficulties. You can see how anger management would also be seen in all three dimensions, where you might ruminate and get more and more upset as you think about things. And you might feel more overwhelmed, and that feeling of being overwhelmed can burst over into a physical outburst, you know, shouting at somebody or losing control, or physically leaving a situation or just abruptly leaving and walking off in a way that is not really calm. If you were managing it well, you might walk away calmly.

So the physical dimension can be an indication of how well you are doing or how difficult the challenge is for you. The same with cognitive and emotional. These are the areas that are really the bigger areas I was evaluating with the tests that I just described to you.

Q. Would it be fair to summarize that because Ms. Torjusen has both emotional diagnoses, PTSD, anxiety, depression, some cognitive findings with regard to

disinhibition, some concentration issues, as well as lingering shoulder soreness periodically from the incident, that one or two of those could set off the third and become kind of a moving target, if you will?

MR. BONVENTRE: Objection.

THE COURT: Sustained.

BY MR. PETRU:

Q. Doctor, can you share with us how Ms. Torjusen's emotional diagnoses could impact her cognitive and physical problems?

A. Sure. I think you can see that heavily from the TSI, is a good way of seeing it, because it affects -- measures relationships, it measures physical concerns, sexual concerns, it measures relationship attachments, it measures anger outbursts. And all of these things have physical, cognitive and emotional dimensions. And her functioning is very high in all of these areas, very, very high in terms of distress level. Her concerns about physical functioning are somewhat less now, but they can pop up again for her. The indications of sexual dysfunction are way decreased, and considered not even problematic. But there is also social concerns, not dysfunction, but who am I, how do I want to relate to people, who do I want to relate to with intimacy, what is intimacy, what is going on with that. We also see that in

her insecure attachments and her difficulty with anger.

So all of these areas definitely relate. And you can see in the outer boxes, the self-image and meaning, she has continued problems feeling worthless. She has problems in managing effective social relationships and difficulties coping at work. She doesn't have a lot of fun, so that's the recreational problem. Financially, she seems to be making a living. Good for her. But money can't buy you happiness, like the old saying goes.

There is a lot of distress that she carries inside of her psychologically that's seen in observable physical behavior, in her emotional life as she presents it, and in the way she thinks about things, and also in her ability to concentrate, stay focused on things.

Q. You saw her five or six times. I can count them up here on my notes.

A. I had five sessions with her after the initial assessment.

Q. Without going through each individual session, is it fair that they were focused on a particular issue, something she was grappling with at the time?

A. We met for five sessions, which I would consider early sessions. It was trying to establish rapport with her, trying to figure out what were the challenges that she was facing so that we could -- I could be in touch

with her reality, and also keeping in mind what findings I had from the assessment that would help me -- help guide me as a therapist about what we might want to work on, that we might be able to help her with, and things I might watch her progress on things to see what kind of things she could manage better on her own, because she was trying. She was trying to live a normal life of a student abroad, which is complicated.

There was nothing about her that made me think she was faking that she was having a hard time. She was struggling to do the best she could.

Q. The sessions that you had with her, she was abroad -- when you saw her initially, was she still in town, was she local?

A. She was when we first met. We had an assessment session, and that was in person. I think we did that on a couple of occasions so I could do some interviewing on one day and do testing on another day, build a little bit of face-to-face rapport, because moving into long distance, online therapy, you know, I knew we needed to build a face-to-face foundation if we could.

Q. This was even before COVID when therapy became entirely online or virtual?

A. That's right. This was before then, right.

Q. Do you know why after the five sessions she didn't

continue?

A. Not exactly. She just thought she didn't want to keep coming anymore. She had a hard time articulating that, which is not uncommon. She was clear that it wasn't that she didn't like me or that she didn't feel it was a good effort that we were making, but she just felt like she had other things she needed to be focused on, and there were certain areas she was doing better, and so I just need to be going out and living my life now. I don't want to really be taking out time to do these therapy sessions.

Q. Have you found in the past that therapy sessions can trigger or rekindle some of the issues associated with PTSD for somebody after a period of time, where going back and talking to a therapist and knowing that the genesis of the issue was trauma and there are lingering effects of the trauma, and you get retraumatized just by going to therapy?

A. That is a possibility. It didn't seem to be that case for her. It seemed more that maybe the therapy we did sort of took the edge off enough that she just thought, you know, I am just going to go ahead with things and see how I can do.

Q. Have you found in your practice that patients who have TBIs and PTSD with persistent symptoms four and a

half years after the original trauma are more prone to have difficulties the rest of their life than those who recover more quickly?

MR. BONVENTRE: Objection.

THE COURT: Overruled.

BY MR. PETRU:

Q. You can answer.

A. Oh, can I answer? Okay. Well, you know, it is unusual -- to work with somebody over a period of five years with PTSD is a bit unusual. I do see people who have had PTSD that I didn't start working with them when the diagnosis was made and the events occurred, and they still have problems years later. It is not uncommon for PTSD symptoms to persist for years, and certainly TBI symptoms can persist for years as well.

Q. You diagnosed her with PTSD?

A. Yes.

Q. And in your last report you actually went through the specific criteria from the DSM. What is the DSM?

THE COURT: Let's take our noon break at this time.

MR. PETRU: Doctor, we are going to take a break with you. We will get back a little before 1:30 to make sure the connection is good.

THE WITNESS: Good. Should I sign off and sign

on later, that would probably be the best thing.

MR. PETRU: Should we sign off and sign on or just leave it on?

THE CLERK: It would probably be best if you mute yourself, and turn off the video camera.

MR. PETRU: Did you hear that? Mute yourself, turn off the video, but leave the connection on.

THE WITNESS: I might have a problem with this, because I can't see my screen right now. So I can't mute and I can't stop my video. I can't do anything because I can't see any buttons on here to work with.

MR. PETRU: Can you just leave the room?

THE CLERK: If that is the case, you might have to sign off and sign back on again, and we might have to reconnect you anyway. It should work when we connect you. We will test you at 1:20.

THE WITNESS: That sounds good. I will try to sign back in about 1:15, if that's okay.

THE CLERK: That's great.

MR. PETRU: Thank you, your Honor.

THE COURT: All right. We are going to take our noon recess. Return at 1:30, and do not discuss the case.

(At this time, the jury exited the courtroom.)

THE COURT: We will see everyone at 1:30.

(Recessed.)

AFTERNOON SESSION

MARCH 30, 2022

THE COURT: All right. We've got him back. We are ready to go. Let's bring in the jury.

(The following occurred in the presence of the jury.)

THE COURT: All right. Everyone, please be seated. We are a little bit later starting. I like to blame -- whenever I'm late getting started again, I like to blame it on the fact that this was a train station once, and trains, as you know, are notoriously slow, but not necessarily Amtrak. Amtrak, I'm sure, runs on time.

MR. BONVENTRE: Always.

THE COURT: I'm taking responsibility, certainly not either of the parties here, for our late start.

Let's resume.

MR. PETRU: That's really refreshing, because I'm always the reason for a delay.

BY MR. PETRU:

Q. Dr. Crossen, welcome back. I see you got all dressed up and put on a coat.

A. I think I had it on earlier. Maybe it wasn't so apparent. Over the lunch break, I noticed someone else in the courtroom had the same kind of tie.

Q. Welcome back. I don't have much more for you.

I want to go to the last report, the 2021 report. In

it you have a section you had titled "summary impressions and recommendations." In the first paragraph of it, I think as you did back in 2018, you go through the actual Statistical and Diagnostic Manual definition of PTSD. I know that's your diagnosis. But for the jury's benefit, can you read the criteria as set forth by the committee that kind of defined what PTSD is?

A. Sure. Sure. This is an international disease classification manual. Her condition meets the following criteria for PTSD: Because the event was, number one, life threatening, and the symptoms have been present in other areas of her functioning. Number two, reexperiencing the original stressful experience through repeated disturbing and unwanted memories, repeated disturbing dreams, feeling very upset when reminded of it, meaning the accident. And three, avoidant patterns involving internally trying not to remember or think about the event, and avoiding external stimuli that are concrete, symbolic reminders of the experience. Four, negative changes in cognition and mood manifested by strong negative beliefs about trusting others, safety in the world, or defects in herself as a person. And, five, marked alterations in arousal and reactivity involving irritable, angry outbursts, difficulty concentrating, and sleeping problems.

And I say that these adverse changes in her personality and behavior were identified during clinical interviewing and in her response to the tests administered.

Q. Are the findings consistent with the history that you gleaned from her regarding the crash in December 2017 and the effect it had on her?

A. Yes.

Q. You then go on and write -- and I am going to have you explain this -- persisting disturbances of emotional regulation and cognitive functioning can persist after traumatic brain injury and might play a role in exacerbating her PTSD.

We had that diagram up earlier which had the cognition and emotion overlapping. Is that what you were referring to here, there is interplay or potential interplay between brain injury -- emotional disturbance, brain injury, and PTSD?

A. Yes, all three areas. "Physical" meaning the brain, and then "emotional" meaning her personality changes, and "cognitive" meaning the changes as just referred to above in cognition, that involved changing -- beliefs where it is difficult to trust others, to feel safe in the world, and see herself as a worthwhile person. Those are all cognitive aspects.

Q. In the next paragraph you write: Based on her previous examination, her history of therapy since the accident, and the findings of the present evaluation, several clinical recommendations are suggested for consideration. Her symptoms of Part D and E seem to be the most prominent and problematic at this point in her life.

D is what you listed as 4 before, negative changes in cognition and mood, manifested by strong negative beliefs about trusting others, safety in the world, or defects in herself as a person. And E is marked alterations in arousal and reactivity involving irritable, angry outbursts, difficulty concentrating, and sleeping problems.

Then you --

A. Right. In my report, they are labeled as D and E, and presenting them now I numbered them, calling them 4 and 5.

Q. You wrote specifically: "The complexity of endeavors and challenges in her life have been increasing substantively since the time of our previous evaluation in 2018, as she was beginning her undergraduate studies. From this point of view, the burden PTSD has been placing on her functioning in areas of life emerging in importance is likely magnified. There is very high risk that this

will persist and continue to significantly limit her functioning."

Did I read that correctly?

MR. BONVENTRE: Objection, your Honor.

THE WITNESS: Yes, you did.

THE COURT: Just a moment. Just a moment, Doctor.

MR. BONVENTRE: He is leading the witness now, Judge.

THE COURT: He is. And he is doing it from the report. You could do it by asking him to refer to the report, and he read it --

MR. BONVENTRE: I will withdraw it, Judge.

BY MR. PETRU:

Q. I read that so -- if I could just back up just a little bit. You wrote: "From this point of view, the burden PTSD has been placing on her functioning in areas of life emerging in importance is likely magnified. There is very high risk that this will persist and continue to significantly limit her functioning."

Now, Doctor, that's your opinion to a reasonable degree of psychological probability, correct?

A. Yes.

Q. And is it your opinion that because of the nature of her overall condition that she will continue to have

significant limiting in her functioning as a consequence of the trauma she suffered?

A. Yes.

Q. On the next page you write -- I will read what you wrote and then ask you a question. You said: "She may feel some caution about considering future therapy. This would be understandable given her perception of limited benefits from her previous therapy and the evident worsening of distress in some areas of her PTSD," e.g., parts C and D noted above.

C is avoidant patterns involving internally not trying to remember or think about the event, and avoiding external stimuli that are concrete or symbolic reminders of the experience.

And D, we read before, is the negative changes in cognition and mood manifested by strong negative beliefs about trusting others, safety in the world, or defects in herself as a person.

Can you explain how the strong showings in C and D, as indicated, would understandably impact or limit her participation in the therapy?

A. Well, the avoidant pattern would come into play because doing therapy would assume because the foundation of the therapy is going to be effective, that she would progressively face these internally disturbing thoughts

and feelings and external stimuli that are symbolic or concrete reminders of the experience.

To overcome those avoidant patterns, which are a symptom of anxiety, our therapeutic process requires exposure to those stimuli, internal and external. And the exposure needs to be done in a safe, trusting therapeutic environment.

Q. Were you finished?

A. She would have to overcome the avoidance to actually get into that environment.

Part D comes into play because you have to trust a therapist to be willing to get yourself into therapy. But negative changes in cognition and mood involve strong beliefs that she can't really trust others, and it is not safe to do that, and that there is something wrong with her as a person.

These are things that -- you have to get through these areas of internal trauma and resistance in order to get yourself into therapy, and she has had some therapy more recently after what I did that she found to be discordant with trust. The therapist tried to have her think that she was really doing something positive when she thought she was doing something negative, that she was relating what happened in the course of her trying to deal with this trauma. So she didn't want to see that

therapist anymore. I think the therapist probably didn't understand --

MR. BONVENTRE: Objection, your Honor.

THE WITNESS: -- they hypothesized --

THE COURT: There has been an objection.

MR. BONVENTRE: How would he know what other therapists did or didn't understand?

THE COURT: A healthcare provider can, in providing testimony about treatment, indicate if there had been communication with another physician, but we haven't had that foundation laid.

While we are interrupting here, there is some background noise occurring here. I don't know whether that is a result of anything at your end.

MR. PETRU: I think it is the papers again, your Honor.

Dr. Crossen, if you could be careful not to move papers. Your microphone is very sensitive to paper, I guess.

THE WITNESS: I'm sorry. Okay.

BY MR. PETRU:

Q. We will move on to a related question. The jury in this case has heard from Dr. Aaron Filler describing discrete and specific injury to Ms. Torjusen's brain, consistent with the findings of a mild traumatic brain

injury, specifically in areas of disregulation, anger. My question is: Does the fact that there has been a finding of a discrete injury to the brain in the area that is also known to associate with PTSD make it more difficult for therapy to have a significant benefit?

A. Yes. And I would like to explain.

Q. Please.

A. I am assuming that this was some measurement that was done sometime in the past. But what we get in our behavioral patterns is habits. And even if that area of the brain is helping now, which I don't know if it is or not, but even if it is, the habit of avoidance and not trusting can still be there, kind of like you can still have a limp even after your leg heals, and your behavior can still have a pattern of avoidance even after the need for it is gone.

MR. PETRU: Thank you, Dr. Crossen. Those are all the questions I have.

CROSS-EXAMINATION

BY MR. BONVENTRE:

Q. Good afternoon, Dr. Crossen.

A. Hello.

Q. Doctor, did you ever get a copy of that report from Dr. Filler?

A. I'm not sure. Is that something that was done during

that time that I was doing therapy with --

Q. Do you know who Dr. Filler is?

A. I'm not sure if I know -- is he the one that assessed the brain function?

Q. Did you ever see a report from Dr. Filler?

A. I'm going to look in my folder and see.

Q. Let me ask you this question before you do that, so we can save some time here. Is there any reference in your reports of your review of a report from a Dr. Filler?

A. I'm going to look at my first report and tell you the answer to that.

Q. Thank you.

A. I don't see a reference to it in the medical records that I reviewed, no.

Q. Thank you. Dr. Crossen, I am going to ask you some questions this afternoon, and if you have difficulty hearing me, please tell me, sir, and I will be happy to rephrase the question. All right, sir?

A. Thank you.

Q. Dr. Crossen, you are a psychologist, correct, sir?

A. Yes.

Q. And you saw Ms. Torjusen at the request of her attorney, correct?

A. Correct.

Q. So you knew when you first saw her it was for

purposes of her lawsuit, correct?

A. Correct.

Q. And, in fact, when you saw her a second time after therapy, when you recently saw her, that was also at the request of her attorneys, correct?

A. It was at her request.

Q. So she hadn't seen you for three years when she suddenly knocked on your door and said: Can you examine me again? Is that what you're saying?

A. I am saying I got an email from her.

Q. So you last saw her on November 30th of 2018, correct?

A. Correct.

Q. And then magically she sent you an email, sir, a couple of months ago that she wanted you to take another examination of her, correct?

MR. PETRU: Object to the form of the question.

THE COURT: Sustained.

BY MR. BONVENTRE:

Q. I'm sorry.

Then out of the blue she calls you and asks you to do another examination?

MR. PETRU: Object to the form of the question.

THE COURT: Sustained.

BY MR. BONVENTRE:

Q. She calls you three years later and asks you to do an examination, correct?

A. The thing I think that is not correct is this "magic," "just in the last month."

Q. Doctor, did she call you after three years?

A. She wanted to see me again for different -- it is not magic.

Q. Doctor, did you --

THE COURT: Just a moment. I want to remind you not to speak over the attorney, and Mr. Bonventre will try not to speak over you.

BY MR. BONVENTRE:

Q. There was a gap of three years between when you first saw her and when you see her again, correct?

A. Correct.

Q. And she told you about her trial, correct?

A. Yes.

Q. And so you understood that you were seeing her for purposes of this trial, correct?

A. No.

Q. Okay. So you thought it was a mere coincidence that you were just seeing her on the eve of her trial? Is that your interpretation, sir?

A. No.

Q. Anyway -- so you drafted a report, your first evaluation, on August 16th of 2018, correct, sir?
A. That's right.
Q. Who did you send that report to?
A. Sent that to the referring attorney from the Hildebrand law firm. I think it was Carol Bosch.
Q. You did not send that report to any of her -- to her physician, correct?
A. I did not, no.
Q. Because, again, the purpose of that report was for purposes of litigation; isn't that correct?
MR. PETRU: Objection. Argumentative. No foundation.
THE WITNESS: No, it is not.
THE COURT: Doctor, just a minute. There was an objection lodged. Overruled.
Now you may answer.
THE WITNESS: It was for the purpose of therapy.
BY MR. BONVENTRE:
Q. So do you normally send lawyers reports about your patients for purposes of therapy?
A. Yes, when they make that referral.
Q. But you don't send it to the doctor, who is actually treating the patient?
A. If it's requested to go to the doctor, if I receive a

request from the doctor. In this case, I don't have records of receiving such a request.

Q. Well, do you know if the doctor ever even knew the patient was seeing you?

A. Which doctor are you speaking about?

Q. Do you know who her main treating doctor is?

A. She has a primary care doctor.

Q. And what is that doctor's name?

A. I don't think I know it right off the top of my head. It has changed over time, because she has been seen in different -- by different healthcare providers in different cities.

Q. So you don't --

A. My knowledge -- go ahead.

Q. So you don't know the name of her primary care physician, and you certainly never spoke to her primary care physician, correct?

A. I have not spoken to the primary care physician. I can't remember if I know the name or not.

Q. So the purpose of the visit on August 16th of 2018, sir, was to, among other things, quote, develop an initial plan of therapy? Is that what you wrote down there, sir?

A. Excuse me. I didn't follow. Did you say the initial report?

Q. In your initial report on 8/16/2018, yes?

A. Yes, that's right.
Q. It was to develop an initial plan of therapy; is that correct?
A. That's correct.
Q. Just so I'm clear, Ms. Torjusen's lawyer was asking you to have a treatment plan set up for his client; is that correct?
A. Yes. It wasn't his client -- her client -- it was Carol Bosch, who is a judge now.
Q. In any event -- and you were hopeful to establish psychotherapy with the plaintiff, correct?
A. That's a possibility. I was hopeful, yes.
Q. You were aware that she was going to the University of Washington; is that correct?
A. That's correct.
Q. And you indicated, sir, in your report of 8/16/2018 that you didn't know what her GPA was, correct?
A. Correct.
Q. And you would have liked to have that information to see how she was doing in school, correct?
A. It would be helpful.
Q. Okay. Do you know as you stand here today what her GPA in school was?
A. I think it is a B-plus average.
Q. You think it is a B-plus average; is that correct,

like a 2.8, 3.0, something like that?

MR. PETRU: Objection, your Honor.

THE WITNESS: It would be more like a 3.5.

BY MR. BONVENTRE:

Q. A B-plus is a 3.5?

A. A 4.0 is an A; a 3 is a B; a 2 is a C. That's the way I have always graded. I have taught college quite a bit.

Q. Have you looked at her transcripts, sir?

A. I still haven't seen it. I relied on her report.

Q. Did she tell you she was a good student, a fair student? What did she say?

A. She said she was trying her best. When I first saw her in therapy, she wasn't certain how good of a student she would be. It was difficult for her.

Q. How about later on when you saw her, did she tell you how she actually did in school? For example, did she tell you whether she made the dean's list or not? Did she tell you in certain semesters she had a 3.9? Did she tell you any of that information?

A. She told me she was doing well in school and got good grades.

Q. So you had indicated something about knowing physical complaints. I am looking at your first report, sir, of August 16, 2018. And it is correct that that report says

nothing about the plaintiff having headaches, dizziness, balance problems or light sensitivity, correct?

A. It says that in part of the report, but I think she reported those things in the questionnaires.

Q. Is there anything in your report that I have that you sent to counsel that indicates anything about headaches, light sensitivity, dizziness or balance problems? Is there anything in your report that says that?

A. Not literally, not in those words. But it covers her health -- multiple health concerns.

Q. In fact, nowhere in any of the reports or treatment records, Doctor, do you say anything about headaches, dizziness, balance problems or light sensitivity, isn't that correct, in none of these reports?

A. Well, I don't agree with you I didn't say anything about it. She did endorse those things on her questionnaires.

Q. But you didn't put it in your reports?

A. I didn't put those specific symptoms in the report, no.

Q. Now, Doctor, you did something called a SIMS assessment, SIMS, sir?

A. Yes, sir.

Q. And a SIMS assessment is something you do -- do you do that in every case?

A. I do it in cases where there is some litigation, yes.
Q. And the reason you do it in cases in which there is litigation is because the DSM, which you were talking about, actually specifically really requires you to do something like that; is that correct?
A. No. It doesn't require that.
Q. Does the DSM discuss the diagnosis -- specific diagnosis called malingering, sir?
A. Yes, it does.
Q. And the DSM does say that malingering is something that should be looked into or be concerned about if the patient is referred to you by a lawyer, correct?
A. I'm not sure if it says that or not, but it would be wise if it did.
Q. It also talks about if there is litigation involved, correct?
A. Usually, if there is a lawyer, there is litigation. We live in a country where there is litigation, and there is always two sides.
Q. Now, I'm just trying to understand your interpretation of the SIMS test, sir. It assesses atypical and infrequent responses. What it really assesses, sir, is whether there are signs of malingering, correct?
A. No.

Q. Is it assessing whether or not there is malingering, sir?

A. It's not assessing whether or not. It is one way of measuring. There is no specific test that we rely on only to establish malingering.

Q. But is that --

A. All the literature on malingering for at least the last 20 years is that we need multiple sources of information.

Q. But is the SIMS test one of the ways in which you assess malingering?

A. It is a part of it, yes.

Q. And just so the jury understands -- and I know you don't believe the plaintiff was malingering, but just so the jury understands, malingering is the exaggeration of physical or psychological symptoms, correct?

A. That's part of the definition, yes.

Q. And it could be for purposes, among other things, for financial gain in a lawsuit, correct?

A. Could be.

Q. So that's something that you are conscious of when you are sent a patient by an attorney, correct?

A. Yes.

Q. And, in fact, you had results there in the SIMS assessment which could be interpreted to be consistent

with exaggeration of symptoms, correct?

MR. PETRU: Objection, vague. By whom?

MR. BONVENTRE: By the plaintiff.

THE COURT: Overruled.

You may answer, Doctor.

THE WITNESS: Okay. What's the question again?

BY MR. BONVENTRE:

Q. The SIMS test, which you administered on August 16th of 2018, sir, was consistent -- there was some signs consistent with malingering or consistent with an exaggeration of symptoms; isn't that correct, sir?

MR. PETRU: Objection. Compound.

THE COURT: Sustained.

BY MR. BONVENTRE:

Q. Or how about: Was it consistent with an exaggeration of symptoms?

A. I testified earlier that the results that I got when I followed the manual for the SIMS said if you get results that are higher than the threshold, you should follow up and find out more about that to see if there is an explanation that would be other than malingering.

Q. My question, sir, was --

MR. PETRU: Excuse me, your Honor.

MR. BONVENTRE: I am not getting an answer to my question, respectfully.

THE WITNESS: I am trying. You keep interrupting me.

MR. PETRU: That's my objection.

THE COURT: You are.

MR. BONVENTRE: I apologize, Your Honor.

THE COURT: It is a little more difficult because we are doing this electronically.

MR. PETRU: Can the witness be allowed to finish his answer?

THE COURT: Do you wish to finish your answer or would you like the question redirected.

THE WITNESS: I can finish what I was saying. I would be glad to clarify if you want more clarification.

When I follow the manual of the SIMS, and it says if you find, you know, items that are beyond the threshold, you should understand those items by talking with and investigating further with the person who endorsed the items about what they -- and in that case see what they meant rather than interpret them algorithmically like you are some kind of IT machine, that if it is over the threshold, therefore it must be malingering.

BY MR. BONVENTRE:

Q. Dr. Crossen, I ask if you could respectfully answer my question. Were there responses in the SIMS test that are consistent with the exaggeration of symptoms?

A. No, I don't consider them exaggeration of symptoms.
Q. Were there -- were there responses --
A. I--
Q. Can I ask another question, sir? Were there responses above the threshold of what is to be expected?
A. Yes.
Q. Thank you.

At the end of your first report, dated August 16th of 2018, am I correct that you indicated, quote, "I am optimistic that her symptoms should continue to resolve with therapy"; is that what you said?
A. Yes.
Q. So as of August 16th, 2018, you were optimistic that with some therapy her symptoms would, quote/unquote, resolve, correct?
A. Correct.
Q. Now, sir, did you, in fact, see Ms. Torjusen thereafter for a couple of therapy sessions? Correct?
A. Yes.
Q. Do I understand that some of them, sir, were done remotely?
A. All of them.
Q. All of them. Okay. So after the initial visit, the therapy sessions were done remotely, correct?
A. Correct.

Q. And where was it, your understanding, that Ms. Torjusen was at the time?

A. In the south of France.

Q. So she was in the French Riviera while you were in your office conducting therapy sessions?

MR. PETRU: Objection, your Honor.

THE WITNESS: No, that's not correct.

THE COURT: The objection?

MR. PETRU: She was in school. Counsel is mischaracterizing where she was and what she was doing.

THE COURT: Overruled.

BY MR. BONVENTRE:

Q. You can answer, Dr. Crossen.

A. It was in her apartment in a city near Nice, as I understand it, and she was not on the French Riviera, as I understand the French Riviera to be the beaches.

Q. Well, you later on during one of your sessions talked about her time spent at the beaches, correct?

A. Yes.

Q. You indicated that she -- that as your sessions, your five sessions went on, she was starting to be, in your words, quote, "able to do more things that she had been avoiding," correct?

A. Yes.

Q. And one of those things she was able to do, which you

specifically point out, was she was able to go on trains, correct?

A. Correct.

Q. In fact, she was going on a lot of trains. It was the main part of her transportation, correct?

A. I don't know what you mean by "main part of her transportation."

Q. Did she frequently ride trains and public transportation while she was in Europe?

A. I'm not sure what you mean by "frequently."

Q. Did she do it more than once during the year she was in France?

A. My understanding is yes.

Q. Did she do it more than twice when she was in France?

A. I don't know if there was more than twice in the time that I was doing therapy with her. But I think it was more than twice by the time I saw her last year.

Q. Did she tell you at one point that she went swimming on the coast and she was going for a shipwreck? Do you remember that one?

A. No, I don't remember that.

Q. Could you check your note of November 9th of 2018?

A. Okay.

Q. Do you see that, Doctor?

A. No, I'm not finding it.

Q. I'm sorry. November 9th, 2018, right in the middle of the page, she went for a swim to see a wreck on the coast?

A. Oh, I'm looking at the wrong date. I'm sorry. It's me. While riding trains, she continues to experience the same ongoing psychological distress. I'm not -- oh, here it is. And then she went for a swim on the coast and recognized a student and made friends with him.

Q. She went to see a wreck on the coast, correct?

A. Yes. I don't know that that means she swam to the wreck. I'm not sure what you mean by that.

Q. Never mind, Doctor.

A. That's not what this was. Whether she was going under water --

Q. Doctor, we will move on to another question.

On November 15th -- could you go to your report on November 15th?

A. Yes.

Q. And at the bottom it said she was planning a trip to Paris. Do you see that?

A. Yes.

Q. And she was hoping also to plan a trip to Bosnia and Croatia by train and bus. Do you see that?

A. Yes.

Q. And that she was looking forward to seeing the coast,

the national park with waterfalls, and Roman ruins. Do you see that?

A. Yes.

Q. The last time you saw her for therapy, Doctor, was November 30th of 2018, correct?

A. Correct.

Q. And you indicated that she was building more confidence in herself as the year proceeded, correct, sir?

A. Yes.

Q. Just so it is clear, Doctor, you didn't discontinue -- you didn't discharge her, she discharged herself, correct, after that?

A. That's correct.

Q. And did she discharge herself because she didn't think you were helping or did she discharge herself because she didn't think she needed to see you anymore?

MR. PETRU: Objection.

BY MR. BONVENTRE:

Q. Or some other reason?

MR. PETRU: Objection. Speculation.

THE COURT: Overruled.

BY MR. BONVENTRE:

Q. Doctor, did she discharge you because she didn't think you were helping her?

A. That's not my understanding, no.

Q. Okay. She discharged you because she didn't think she needed to see you anymore? I believe that's what you said on direct, correct?

A. I think what I said on direct was that she thought she could manage on her own, and she would like to give it a try.

Q. Okay. So you don't see her again for literally almost three years, correct?

A. Correct.

Q. And she comes back and you say she requests a psychological evaluation in November, correct, on November 8th of 2021?

A. Oh, the opening sentence says that she expressed interest in consultation to assess her current functioning about college following her earlier therapy. And when I talked with her, she said that she wanted to know whether she -- my recommendations about any further therapy.

Q. So this is after a three-year absence she wants to consult with you again, correct?

A. Correct.

Q. But she did tell you that her trial was coming up, correct?

A. I think she probably did, sure.

Q. And she did ask you to send a letter -- a report to her attorney, correct?

A. Correct.
Q. And you sent the report to an attorney, but not to the plaintiff's doctor, correct?
A. I was not requested to do that, no. And it is not common to send reports to doctors unless the patient requests that, and then would request it be sent to their doctor, or the doctor would say: Can you request that for me. This is just normal stuff for everyday therapy. This was not just something that happens in a law case.
Q. Let me ask you this: It is normal to send reports to the patient's lawyer, but not the patient's doctor; is that what you are saying?
A. No. I said it is not normal to send a report to the patient's doctor unless it is requested.
Q. Of course, it is correct that the doctor can't request the report if the doctor doesn't know you are seeing the patient, correct?
A. That's correct. That is very common. It is just standard, the way therapy is done. That may be a surprise to you as an attorney, but to me as a psychologist and therapist, that's the way things are.
Q. So she told you that she had graduated from the University of Washington with a triple major, correct?
A. Correct.
Q. And the major was in political science, emphasizing

economics, international studies of the Middle East, and near eastern languages and civilization, correct?

A. Correct.

Q. She told you that at the start of June of 2021, she left the United States again and was going to go to Romania for a month, correct?

A. Correct.

Q. And then she was going to move permanently to Cairo, Egypt, correct?

A. Correct.

Q. And she also told you that she was working --

A. I'm not sure what you mean by "permanently." I don't think she said that. I think you might have put that into your own interpretation.

Q. Well, she didn't indicate a time when she was returning. She was going to live in Cairo, Egypt, correct, sir?

A. As a 24-year-old woman she said, yes, that's what she was going to do next. That's what her plan was.

Q. Do you know if that's where she is living now?

A. At this moment, unless there has been a change, I think that's what she is doing. But I don't know at the moment.

Q. Okay. She also told you that she was working full time as a CEO for a start-up company, correct?

A. Correct.
Q. And that she was -- had six people who were reporting to her, correct?
A. Correct.
Q. And that she was writing articles and editing other articles of other people, correct?
A. Correct.
Q. Now, Doctor, by the way, did you have atypical responses once again on that SIMS exam?
A. Yes.
Q. But you didn't think it was malingering or had anything to do with the lawsuit, correct?
A. From what I understood what those items were, to me they were very valid considering her condition and they would not be atypical for her condition. Keep in mind, her condition is PTSD, and the SIMS is not normed on people who have PTSD. So there is an amount of interpretation that needs to be professionally applied there to see what do these items really mean. Like I said, it is not an algorithm, it is a clinical judgment tool.
Q. And that interpretation is done by you, correct?
A. Of course. I am writing the report, I'm responsible for the interpretation.
Q. The report that is going to a lawyer involved in a

lawsuit, correct?

A. Correct.

Q. Now, you were justifiably incredibly impressed with what Ms. Torjusen had been accomplishing, correct?

A. I was quite impressed.

Q. Yes. It is quite impressive what her accomplishments have been through college and through the present time, isn't that correct, sir? In terms of her grades, in terms of her writing, in terms of her employment, in terms of all those things, her traveling, it is incredibly impressive what she has done, correct?

A. I wouldn't say incredibly impressive about the travel, because she has expressed that travel is very uncomfortable for her. I wouldn't say that these are unmixed achievements. They take a toll on her. It is hard for her to do what she is doing.

Q. It would be hard for any 24-year-old to do what she has been doing, isn't that correct? I mean, what she is doing is pretty extraordinary. It would be hard for anyone at that age -- at any age -- to do all the various things that she has accomplished; isn't that fair to say?

A. All of the various things, I think she is doing really great in her school and work. I don't think she is doing well in her emotional life, her social life, and in her ability to do those work skills without cognitive

discomfort and emotional discomfort.

Q. Did you indicate that she has shown great skillfulness in managing to complete a rigorous academic program and do multiple -- multiple highly responsible jobs, correct?

A. Correct.

Q. And then you close the report by indicating again, like you did with the first report, that you have optimism for Emily's potential further recovery, correct?

A. Yes, with therapy.

MR. BONVENTRE: Thank you, Doctor.

THE WITNESS: You are certainly welcome.

REDIRECT EXAMINATION

BY MR. PETRU:

Q. Dr. Crossen, you think therapy can help?

A. I do.

Q. Not a cure-all, right?

A. Not in this case, no.

Q. The rule of completeness, if you can turn to the October 26th, 2018 report from your visit with her. Counsel touched on this. I want to ask you a couple of questions. This is when she is doing very well in school, apparently. Are you there?

A. I am just about there. The 6th of October.

Q. 26th.

A. Oh, 26th. I'm sorry. I am turning these pages slowly. I don't want to create that noise that is so bothersome to everybody.

Q. I appreciate your sensitivity. I really do.

A. You know, it has been brought up a couple of times, and I am a little shy about it. Okay. I've got the report, the update.

Q. There is a paragraph called "assessment." In the middle of that paragraph she is talking about something in school while she was in France. And there is a sentence that became -- that starts "she became angry." Can you please read what you wrote on October 26th, 2018?

A. Well, the context is that they were doing a project. It was difficult trying to get the approval of a teacher she felt was mean to her. That was her own feeling about it. And she took it as a sign that the teacher was mean to her to make her tougher, almost like a coach might yell at their players.

Q. And then you wrote she became -- can you read that, please, slowly?

A. "She became angry when the other students were announced as the winners. She thought the result was fraudulent, yelled a profanity, and walked out. She cried later when she met with the teacher who blamed her for her prickly reaction and refused to stop the meeting."

Q. Is that a person who is succeeding without any problems?

A. No.

Q. Can you please read the next section under "plan" slowly in its entirety?

A. "When we talked about her current symptoms from the train wreck in April, she said there was no way around taking trains in Europe. She recounted being negatively triggered emotionally by the high speed, sudden noises, and dark tunnels. She cannot avoid the experience and the memories it evokes. She copes with a chip on her shoulder. We plan to meet again in one week."

Q. Can you now turn to your November 9th, 2018, report?

A. I'm there.

Q. I think you read this in response to one of counsel's questions. This is less than a month later. In the "objective" section you wrote, quote, "While riding trains, she continues to experience the same ongoing psychological distress." Did I read that correctly?

A. Absolutely correct.

MR. PETRU: Thank you. Those are all the questions I have.

MR. BONVENTRE: I have one or two very quick ones.

RECROSS EXAMINATION

BY MR. BONVENTRE:

Q. That very powerful discussion about how upset Ms. Torjusen became when some teacher didn't like her project or something like that, do you remember you just talked about that like three seconds ago?

A. Yes.

Q. On October 26th of 2018?

A. Correct.

Q. Was that since the Amtrak accident or did that occur when she was in high school?

A. I didn't hear -- I don't understand your question.

Q. Could you look at October 26th of 2018.

A. Yes.

Q. And you talked about someone else was declared a winner, and someone was mad, and the teacher was mad at her. Do you remember that?

A. Yes.

Q. You took that as a sign that she wasn't doing perfect. Remember? You just answered that question for counsel, do you remember?

A. Yes.

Q. When did that happen? Look at your first sentence in that paragraph.

A. Yes.

Q. Did that happen when she was in high school?

A. Yes.

MR. BONVENTRE: Thank you. Nothing further.

FURTHER REDIRECT EXAMINATION

BY MR. PETRU:

Q. Did Ms. Torjusen relate similar experiences she had with teachers and students while she was in college during the sessions with you?

A. Yes.

MR. PETRU: Thank you. Those are all the questions I have.

FURTHER RECROSS-EXAMINATION

BY MR. BONVENTRE:

Q. Apparently, she was having these problems before the train accident, correct?

A. You are too far away from the microphone.

MR. BONVENTRE: I withdraw the question, Judge.

THE COURT: Thank you, Doctor. You are excused.

THE WITNESS: You're welcome. Thank you.

MR. PETRU: We will go to a live witness at this point.

THE COURT: Call your next witness.

MR. PETRU: I would like to call Dr. Meghan Spohr.

THE COURT: If you would step up to the bench,

hold up your right hand, the oath of witness will be administered.

MEGHAN SPOHR,

having been sworn under oath, testified as follows:

THE COURT: Thank you. Please have a seat here at the witness chair.

DIRECT EXAMINATION

BY MR. PETRU:

Q. Good afternoon, Dr. Spohr.

A. Good afternoon.

Q. What kind of medical practice do you have?

A. I work in outpatient medicine.

Q. Describe the practice, if you will, please.

A. In the last about 15 years, I have seen a range of and age of patients from birth until death. I do internal medicine and pediatrics and carry board certifications in both.

Q. Where did you go to medical school?

A. University of Kansas.

Q. And where did you do your residency?

A. University of Michigan.

Q. When did you first meet Emily Torjusen?

A. Exact date --

Q. We don't need the exact date.

A. Over -- I would say over eight years ago.
Q. Your deposition and medical records indicate it was 2008.
A. Okay.
Q. Is that consistent with your best recollection?
A. Yes, it is.
Q. She was about eleven years old?
A. Yes.
Q. From the time that she was eleven, did you continue seeing her as a pediatric patient?
A. I did.
Q. And did you continue into her early adult years?
A. I did.
Q. The records that we have indicated that you saw her on December 22nd of 2017.
A. That is correct.
Q. And you are in a unique position as a professional who knew her both before and after the incident, the crash -- train crash?
A. That's correct.
Q. I will ask you questions about your diagnosis, treatment. Will all of your answers be to a reasonable degree of medical probability?
A. Yes, they will.
Q. Let's start off kind of at the end. Can you share

with the jury, please, your observations of Emily before the incident, comparing them to your observations of her afterwards?

A. When I saw Emily as a pediatrician for well-child visits and for various complaints, it always struck me that Emily was fairly reticent, shy, not really much of a complain -- didn't really complain much.

When I saw Emily after her accident, most recently the last two years, she was anxious, definitely not reticent, tended to blurt things out, had a hard time stopping talking sometimes. Didn't really seem -- there was a marked difference.

Q. As a result of the train accident, did you formulate any opinions or conclusions from your position as an internal medicine doctor and pediatrician as to what injuries Emily sustained as a consequence of the train accident?

A. I thought her complaints and behavior were very consistent with post-traumatic stress disorder, as well as post-concussive syndrome as a direct result of the concussion with loss of consciousness due to a traumatic brain injury sustained in the crash.

Q. What are the bases for that opinion -- those opinions?

A. Mainly observations and diagnostic testing, as well

as my knowledge as to post-concussive syndrome, as well as PTSD, and complaints that the patient, Emily, brought up, as well as my observations.

Q. Your knowledge and understanding of post-concussive syndrome and PTSD, how did you gain knowledge or understanding of those two conditions?

A. Both from reading and treating patients.

Q. Something as a general practitioner, as an internal medical specialist, and as a pediatrician you are trained to look for signs or symptoms consistent with those two diagnoses?

A. Yes, we are. We do a lot of, especially in pediatrics, concussion treatment.

Q. You responded that you formed these opinions based on both talking to Emily and observing her. Let's start with the observing her. What sort of observations have you made of Emily that help inform your decision or your diagnoses?

A. I would say more particularly Emily was never an anxious person before the incident. So she showed signs of anxiety, as well as expressed that that was a problem. She complained of trouble concentrating. And I saw her for years. She didn't have trouble with school, was never diagnosed with any attention deficit disorder, and all of a sudden she is having trouble concentrating, getting

schoolwork done, just actually with activities of daily living, organizing her life. So that's what I would say I would be observing.

Q. Did you -- with regard to the issues that you just described, did you prescribe for her any medications?

A. I did.

Q. What did you prescribe?

A. The first medication I prescribed was a medicine that helps people concentrate that is used frequently in patients who have trouble concentrating with post-concussion syndrome, but also with attention deficit disorder called Concerta. The second medication I prescribed was a medicine to help deal with anxiety, which was Citalopram. The third medicine I prescribed was another medicine specifically for PTSD, although it can be used for anxiety, which is called Buspar.

Q. From time to time, did she take those medications from your understanding?

A. To my understanding, she did.

Q. Did she at times report she couldn't take them for various reasons?

A. Yes, she did.

Q. And what were those?

A. One of them was that she was traveling overseas and wasn't sure that the medicine was permitted in other

countries. Initially, she actually was hoping not to have to take medications, so she didn't want anything for it. But after trying without it, then she agreed to try the medication. So those are the two reasons I think she expressed to me.

Q. Did you ever experience any emotional disregulation or emotional lability with Emily since the accident?

A. Yes. There was a visit I believe second from the last in 2020 where she definitely had emotional disregulation. She seemed quite upset, got red in the face, cursed a little bit, which is not at all like Emily, during the visit. So, yes.

Q. Did she cry?

A. Yes.

Q. I would like to go through your visits with her starting with the first one post-incident, December 22nd, 2017. In it, what did you report in terms relative to the train accident? I know your records have other nonrelated medical issues, so we are not going to go through any of those. But relative to the crash, what were your observations on December 22nd of 2017?

A. Her arm was in a sling due to a clavicular fracture. She had several lacerations, some of which had stitches and required removal. And she had some light sensitivity and had complained of a headache.

Q. What is the significance of light sensitivity?

A. It goes with headache. Headache or concussion. Common symptom.

Q. You reported that she had a consistent headache at that time?

A. Yes.

Q. What was the significance of the fact that the headache was consistent?

A. It's just common if you have a significant enough concussion to have your head hurt for a long period of time.

Q. By the way, have you had patients who have had concussions -- combination of concussions and PTSD before?

A. Yes, I have.

Q. Have you had patients who have had concussion and PTSD who got better?

A. Yes.

Q. Have you had patients who have had concussion and PTSD who have not?

A. Yes, I have.

Q. You noted -- and because of the electronic medical records, I wasn't quite sure when you wrote this. But at one point you said, "So far no complaints of concentrating yet." What did you mean by that? I think that was on the first visit.

A. It's common -- I have noted, and also in the literature, that patients who get concussions do have trouble with concentration. So I would like to preface and like to at least put this in chart notes. Sometimes insurance plans don't like to cover medication for concentration, i.e., Concerta, especially if the individual does not have a diagnosis of attention deficit disorder maybe before the age of 18. So I like to keep -- to at least put it in my records whether or not that is a complaint. It is something that I am not surprised if I hear.

Q. Did you expect that based on her symptomology and your observations Emily might be at risk for developing concentration problems?

A. I did, because she -- she had a pretty significant head injury and lost consciousness. And she was trying to go to college. So I was suspicious it might happen.

Q. And did that inform your plan where you wrote, quote, "It would not be unusual to have trouble with concentration and chronic headache for a couple of months with post-concussion syndrome"?

A. Yes.

Q. And when did you write that, if you remember?

A. That was, I believe, in 2017, 12/22.

Q. And did you, in fact, based on your subsequent

history and discussions with Emily, find that she did develop problems with concentration, and she did have persistent headaches for a couple of months, if not longer?

A. Yes, she complained of that.

Q. Did you discuss with Emily the anticipated problems that you saw that she might have with school as a result of her head injury and PTSD?

A. Yes, we did discuss that.

Q. Actually -- let me back up a little bit. Initially, was your primary focus in this regard on the concussion and the sequelae of the concussion rather than focusing on PTSD early on?

A. Right. The focus was primarily on concussion.

Q. What did you tell her, what did you do relative to your anticipated problems that she would have with school?

A. So we talked a little bit about medication, which should be in the record, about gabapentin that I use sometimes for the head pain because analgesics don't work that well, and we wanted to avoid any sort of significant narcotics.

I also talked about medications to help her with concentration, and talking to her college about perhaps getting accommodation if she had trouble with her classes. It is -- you know, it is hard to concentrate when your

head hurts or you have trouble concentrating.

Q. And did you write such a letter for her?

A. I did.

Q. I believe it is an exhibit. I don't have it right in front of me. As part of your practice, do you communicate with patients periodically through phone messages or emails or similar text correspondence?

A. Yes, we do.

Q. Did you receive a communication from Emily on January 14th, 2018, regarding her condition?

A. I did.

Q. Do you have that in front of you?

A. I do.

Q. Can you get that?

A. It may be a minute here. Okay.

Q. Can you read what she wrote to you on that date?

A. I'm reading through the deposition. Sorry. This is a lot of pages here. Okay. I have one from later. She said -- I don't have the exact -- sorry.

Q. Let me help you. I've got it. January 14th, 2018: "I'm having trouble focusing in class and when reading my books. I keep getting up and doing other things or my mind just wanders. Overall the headaches are pretty manageable, though sometimes I get big mood swings, but I am having trouble waking up in the mornings. Is there

anything I can do to try to fix these?" That's the end of message.

A. Yes.

Q. Did you respond to her?

A. I did, and suggested she try Concerta that we had talked about in December.

Q. Can you go ahead and read what you wrote to her or do you want me to do that, too?

A. Yeah, if you could. I have the next one, but not this one.

Q. All right. On the 17th you wrote: "Hi, Emily. You can try taking medication for attention deficit disorder/trouble cont, attention deficit disorder if the headaches were okay. It is pretty typical of someone with a concussion and can take months to go away. Sometimes this medication is helpful and sometimes it is not. I would be happy to call some of these medications, Concerta or Adderall, in for you if you would like to try."

Did I read that --

A. You did.

Q. Is that consistent with your memory?

A. That's correct.

Q. In March of 2020, I believe timed during a break when she was going to come back from school, you had some discussion with her mother, correct?

A. Yes.
Q. And you knew her mother?
A. I did.
Q. And what was the interaction with her mother about in March of 2018?
A. Wanted to have neuropsych testing -- neuropsychological testing, because she was having difficulty with concentration at school and wanted to see -- get concrete data as to what could be wrong.
Q. Neurological -- is neuropsychological testing something that you order periodically on behalf of your patients?
A. I do.
Q. Did you have any quarrel or disagreement or concerns about Patty Torjusen, Emily's mom, making that request on Emily's behalf to you?
A. No, I did not.
Q. To whom was she referred?
A. Initially, she had requested an individual in Seattle, but I think she was home on spring break, and Scovel Psychological in Vancouver had openings and so she was referred there.
Q. Are you familiar with Scovel Psychological in Vancouver?
A. I am.

Q. And have you made referrals directly to Scovel Psychological in the past?

A. Yes, frequently.

Q. And did you in this case?

A. Yes, I did.

Q. Did you at some point receive the report from Scovel Psychological?

A. I did.

Q. What did that inform you of? What reaction did you have when you got that and reviewed it, Dr. Scovel's report? We will be hearing from her soon.

A. It seemed consistent with post-concussive syndrome and difficulty with concentration, which is -- a definite concentration deficit, is what they noticed.

Q. Did you get directly involved in Emily's psychological care at that time?

A. No, I did not.

Q. Is that something that you do or don't do or it depends?

A. It depends.

Q. You -- I didn't establish this. Where are your offices?

A. In Vancouver.

Q. And where was Emily at this time?

A. Seattle.

Q. Does that create some issues for you and problems with referral and treatment?
A. Yes, it did.
Q. Do you have other patients who are peds that you saw and became young adults and went off to school and you are trying to figure out what to do for them from tens or hundreds or thousands of miles away?
A. Yeah, we make a lot of referrals to other states.
Q. I believe the records indicate you next saw her on July 16th, 2018, correct?
A. Um-hum.
Q. Do you have that in front of you?
A. I do.
Q. When you saw her on July 16th of 2018, what were her subjective complaints?
A. Sorry. Let me get through my papers here. I believe she was complaining that her headache had improved, but she still had issues with concentration.
Q. Do you have them in front of you?
A. No. Here we go. Yes.
Q. I have notes where you noted that she had anxiety associated with PTSD, headaches --
MR. BONVENTRE: Objection, your Honor.
THE WITNESS: I've got it.

BY MR. PETRU:

Q. Thank you.

A. Do you want me to read --

Q. What were the subjective complaints at that time?

A. Anxiety. She didn't feel that anxiety was bad enough that it required medication. She had some issues consistent with post-concussive syndrome still because she had a lot of difficulty concentrating, but remarked that Concerta was helpful when she took it during her last semester, although school was still very difficult. She was planning to go abroad, so she is not sure if she can continue taking the medication, so she was concerned about that. She was noting that her headaches had improved. And that she was having some issues with memory -- short-term memory, such as she went to workout the other day and forgot that she left clothes in her car, as an example. So those were her complaints.

Q. Did she report any sleep problems and nightmares at that time?

A. Yes. She did complain that she occasionally had difficulty sleeping with nightmares.

Q. And did she report depressive symptoms?

A. She did report some. There is a typo on this that says she does have noted depression -- some noted depressive symptoms, is what that's supposed to say.

Although it does say she has no depressive symptoms.

Q. So the answer is she did have depressive symptoms?

A. Yes.

Q. Did she report difficulty multitasking?

A. Yes.

Q. And as you said, you discussed with her medications or possible medications she may or may not be able to take to France?

A. Right. Specifically stimulants. Oftentimes stimulants in other countries are not accepted.

Q. And then she is off and she is studying in France, and as the jury has understood or will understand, she was in France, and then Egypt for the better part of 2018 and into 2019, and then she came by and saw the office in September of 2019 for a routine physical examination, correct?

A. Yes.

Q. And in that I noted that there was occasional references to twinges in shoulder and collarbone. Did I read that correctly?

A. Yes.

Q. What significance did that have, that year and a half -- actually closer to two years post-incident she still had some twinges in the shoulder and the collarbone?

A. Those probably directly related to the clavicle

fracture. Most of the time you don't fix clavicle fractures. You just let them heal on their own, which unfortunately they don't always heal exactly like they are supposed to and cause some ligament damage. It is not necessarily unusual that it continued to bother her.

Q. That didn't surprise you that two years later or so she still had complaints in that area?

A. No. Hum-um.

THE COURT: We will take our afternoon recess at this point. Fifteen minutes. Please do not discuss the case.

(At this time, the jury exited the courtroom.)

THE COURT: You can step down. Return in 15.

(Recessed.)

THE COURT: You may resume your seat, and we will bring in the jury.

(The following occurred in the presence of the jury.)

THE COURT: Everyone, please be seated. Mr. Petru, you can resume.

MR. PETRU: Thank you, your Honor.

BY MR. PETRU:

Q. Dr. Spohr, home stretch. We will let you get out and drive for a while. We last spoke of the September 23rd, 2019 interaction. I would like to go to October 9th, 2020. Let me know when you have that in front of you.

A. I do.
Q. What occurred on that day?
A. The patient came in for a physical.
Q. And while there, did you speak to her about problems she was having associated with the sequelae of the train wreck?
A. I did.
Q. And what did she report?
A. She said that she actually was having trouble with stress, difficulty paying attention, as well as she had noted a personality change. She said she was -- she was losing all of her contact with her friends. She tends to blurt out things without thinking about it, and afterwards think, why did I say that? That had led to a lot of misunderstandings and loss of friendships.

She also had trouble, she mentioned, controlling her life, as well, just organizational wise, and that had led to a lot of increased stress and anxiety and decreased enjoyment in doing things. She asked for some names of counselors that she might be able to get through her insurance, and wasn't able to get in.

This was during the pandemic, and trying to get -- when the pandemic was at its height, and it was difficult to get a counselor. And she was having a hard time doing so.

She was having a hard time -- like she really enjoyed her job, but getting there and getting motivated, she would sit in her car and cry. Once she actually went in to do her job, she was fine with it, but it was the getting there that was hard.

She didn't have a lot of headaches still. She missed a whole semester of college. She said she has just not been able to keep up, not being able to concentrate.

And she had mentioned to me that because she was living in Seattle, she had seen some providers up there and had been prescribed some antidepressants, and that it didn't really seem to work for her, at least the ones she had been prescribed.

She wasn't talking to her father, with whom she had a good relationship before this, but did mention she had a relationship with her mother and her sister.

THE COURT: If you would, when reading just go a little slower so our court reporter can pick it up. Thank you.

THE WITNESS: I apologize.

BY MR. PETRU:

Q. Did you list a diagnosis with regard to the train incident on that day?

A. Yes. I listed a diagnosis of PTSD, as well as post-concussive syndrome. Along with the PTSD, I thought

she had more depression than sometimes you might see with strictly a diagnosis of PTSD, and recommended medication.

Q. Did you write "major depressive disorder"?

A. Not on that visit, no, I did not.

Q. You prescribed -- or indicated a prescription for Xanax, Buspar, Lexapro and wanted her to see a counselor if she could, correct?

A. Yeah. The Lexapro was something she had been prescribed through providers in Seattle. And that was one of the ones she had mentioned didn't work for her. So I had prescribed Citalopram and Buspar at that time.

Q. We know she saw a counselor at the end of 2020 into 2021, Donna Johns. Did you facilitate her seeing Dr. Johns, or was that someone she was able to find through different sources?

A. That was able -- that was somebody she was able to find through alternative sources. One of the things, to clarify, in medicine that we don't typically do, insurance allows patients to get their own counselors. It is difficult to actually make a referral and have someone go. That is not -- we can make a recommendation, but it is not referral based.

Q. Did you find in October 2020, least we forget, that was our seventh month, eighth month of COVID, as a practitioner, did you find that patients were having a

hard time finding counselors at that time?

A. Extremely.

Q. You next had an encounter with her May 17th of 2021, correct?

A. That's correct.

Q. And what happened on that occasion?

A. She was in the office for follow-up. Some of the issues were not related to --

Q. I am just asking about issues related to the train crash.

A. She specifically said her headaches she continued to have infrequently, but she wasn't someone who had headaches before. But she wasn't having consistent headaches.

Q. She was having headaches but not as consistent as she had back in December of '17?

A. Yes, of 2017. Yes. She still had trouble concentrating, she mentioned. And she did feel that the Citalopram was useful for the PTSD and depressive symptoms.

Q. I asked you earlier about Dr. Scovel's report. You got that sometime after Dr. Scovel did the initial report back in 2018. Did you also get -- and I believe our office sent it to you, Dr. Filler's report?

A. I did.

Q. And did Dr. Filler's report -- first of all, had you already made a diagnosis of PTSD and post-concussive syndrome before you got Dr. Filler's report?

A. Yes.

Q. Was it consistent with or inconsistent with the findings in his report? Were they consistent or inconsistent with your findings?

A. Entirely consistent.

Q. I have a note here. This is from a discussion that we had I believe in your deposition about the effect of appointments or somebody trying to keep appointments who has the kind of anxiety Emily has exhibited. What problems does that create?

A. People with PTSD and chronic anxiety or depression with more anxious features have more anxiety about more appointments. So the more that gets layered on them, the more they are required to do, the idea of going into an unfamiliar place causes more anxiety, which then they tend to avoid. So you have to be somewhat limited and careful in what you target. Too many appointments and they won't go at all.

Q. Thank you. I think you said in your deposition, you used the term "a huge incidence of noncompliance if there is overload"?

A. Yes.

Q. What do you mean by that?

A. The number of patients who stop their medication, who stop following up with providers, who don't come in, is significant.

Q. Let me unpack that a little bit. Is it significant in specific populations, whether they are adolescents or young adults or older adults? Is there a correlation between age, the nature of the injuries, the noncompliance because of the nature of the injuries? I guess those are all questions, and you can take whichever ones you want.

A. Well, older patients tend to come in more. They are retired. And then younger patients tend to have a feeling of, I can just get over it more so than older patients do. Also, quite honestly, older patients like the doctor more, just in general. I am older, so --

Q. No, you're not. I will be the judge of that.

With regard to therapists and patients such as Emily, not in terms of coming to see you as a PCP, but in terms of seeing a psychologist or psychiatrist, does an increase of appointments in that realm also trigger this high incidence of noncompliance based on your experience?

MR. BONVENTRE: Objection.

THE WITNESS: Do I go ahead and answer?

MR. BONVENTRE: I will withdraw.

THE COURT: The objection is overruled.

THE WITNESS: If I understand the question correctly, yes, they tend not to go to counseling.

BY MR. PETRU:

Q. You indicated in your deposition that you believe that Emily could benefit from a wide variety of therapies and counseling if she can get to a point where she can do it. Fair?

A. Yes.

Q. What are the different modalities that you offered in your deposition?

A. Well, I mentioned cognitive behavioral therapy as an option, just having a counselor to offload. So regular counseling. Cognitive behavioral therapy, I thought she would benefit from. I also thought she would benefit from ongoing medication. But she was doing fairly well on the options that we had done, so I didn't at that point feel that psychiatry was indicated.

Q. You also indicated occupational therapy. What is that?

A. Yeah. Sometimes occupational therapy can help people with post-concussive syndromes and PTSD with organizational, with life skills, with -- sometimes even we have an occupational therapist that works a little bit with vestibular therapy, which helps a little bit post concussion -- when they specifically have vision issues or

dizziness or ongoing headaches.

Q. Do you work with speech/language pathologists, as well?

A. We do.

Q. Would speech/language pathology be an appropriate area if Emily had the ability and -- the ability to get to appointments and see appointments if there is an SLP? Would that be of help?

A. I didn't think in Emily's case it would, no.

Q. Why not?

A. She didn't seem to have -- it wasn't the speech, it was controlling the speech. It was more impulse control. It was more inappropriate social behavior, saying things that she should -- we think when we see somebody, but we don't say because it is rude. That is not going to get better with speech therapy. Speech therapy helps people post-concussion when they stutter or they have word-finding difficulties, of which I have seen, but Emily was not one of them.

Q. She has excellent word skills, correct?

A. Yes.

Q. That part of her brain was not affected?

A. No.

Q. When you last saw her, did she still exhibit signs and symptoms consistent with your initial findings back on

December 2017?

A. She did.

Q. Based on the time that had passed, four and a half years or so -- four years when you last saw her, did you expect that she would have significant difficulties going forward based on the chronicity of her problems?

A. Yeah, I did.

MR. PETRU: Thank you. Those are all the questions I have.

CROSS-EXAMINATION

BY MR. BONVENTRE:

Q. Good afternoon, Doctor. How are you?

A. Good. Thank you.

Q. Thank you for coming in. Just one quick question before we start, what semester of college were you told that she missed?

A. She just said she missed a semester of college. As an MD, I am not going to ask specifically as far as education is concerned, so I don't know. I don't know if she didn't complete that semester completely or if she missed the whole semester, and I didn't clarify.

Q. I'm not saying that you should have. My question is: Do you know if, in fact, she did miss a semester of college?

A. I do not.

Q. Doctor, you're at the Vancouver clinic; is that correct?
A. Yes, it is.
Q. And the Vancouver -- you're not the only doctor, obviously, at the Vancouver clinic, correct?
A. No.
Q. There are doctors in different departments, as well?
A. Yes, there are.
Q. So there is an orthopedic department?
A. Yes, there is.
Q. And Ms. Torjusen was actually seen on a couple of occasions in the orthopedic department, correct?
A. She was.
Q. And you had those records -- as the internist and the primary care physician, you have the records in front of you?
A. I do not have those records in front of me.
Q. So you didn't bring the records with you from the visits that she has had post-accident when she saw the orthopedist?
A. I brought the records with me, my records, not other people's records. I was not told to do so.
Q. You are aware that she was treated at the Vancouver clinic for physical injuries early on that she sustained, correct?

A. Yes.
Q. Did you review those records?
A. Yes.
Q. Although you don't have them with you now, you did review them. Were you aware -- I take that back. You were aware, Doctor, that histories were taken every time she came to the Vancouver clinic, and a physical exam was done every time she came to the clinic, and a review of systems was done every time she came to the clinic, correct?
A. Yes.
Q. And a "review of systems" is what is bothering you; is that fair to say?
A. Within reason, yes.
Q. And a physical exam is you do a physical exam, and there is a form that is part of the records basically from head to toe so to speak; is that correct?
A. Yes.
Q. And it includes neurological, how the patient is doing neurologically, and it includes how is the patient doing psychologically, psychiatrically, correct?
A. Within reason, yes.
Q. Well, it is not a question within reason. That's the form. The form says "neurologic," and the doctor fills something out based on his or her exam, and the form says

"psychiatric," and the doctor fills something out based on his or her exam?

MR. PETRU: Objection. Speculation.

THE COURT: Overruled.

THE WITNESS: Yes. But that is dependent on the various difference. I agree with you. I just wanted to clarify that sometimes emphasis is put on different parts, depending on which clinic you're at. For example, orthopedics doesn't care as much about psychiatric issues. They get -- for example, you go to urgent care, they get the height wrong a lot of times. Yes, within reason. Yes, I agree with you.

BY MR. BONVENTRE:

Q. Are you saying that, Doctor, because you are fully aware that when she went to the orthopedic wings throughout her four years after the accident, on each and every occasion the neurological exam was normal and the psychiatric exam was normal?

A. No.

MR. PETRU: Objection. Assumes facts not in evidence.

BY MR. BONVENTRE:

Q. Is that in fact what happened, Doctor, that the neurological exam was normal every time and the psychiatric was normal every time?

MR. PETRU: Objection. Assumes facts not in evidence.

MR. BONVENTRE: I'm asking.

THE COURT: Ask one question at a time.

BY MR. BONVENTRE:

Q. Is it correct that the neurological exam was normal?

MR. PETRU: Objection. Assumes facts.

THE COURT: You can lay a foundation.

BY MR. BONVENTRE:

Q. Neurological examinations were done each and every time the patient came into the clinic, correct?

A. No.

Q. Okay. Did doctors indicate each and every time the patient came to the clinic that they had, in fact, done a neurological exam, and they gave a response as to what it was?

MR. PETRU: Objection. Assumes facts.

THE COURT: She indicated she reviewed the medical records. The objection is overruled.

THE WITNESS: I don't remember the records, so I can't state for sure. But as far as I recall, the neurologic exam was not abnormal as stated in those records.

BY MR. BONVENTRE:

Q. And each time those other doctors saw the patient

they wrote "alert and oriented," "mood normal," and things like that. Do you recall that, sir -- Doctor?

MR. PETRU: Objection. Assumes facts.

MR. BONVENTRE: I am asking if she reviewed the records.

THE COURT: Overruled.

THE WITNESS: I don't remember that one way or the other, honestly.

BY MR. BONVENTRE:

Q. It would be fair to say that multiple x-rays were taken of the pelvis and the clavicle and the shoulder, and all of those x-rays -- each and every one of them -- were negative with the exception of the clavicle, correct?

A. That's correct.

Q. And it also would be fair to say that the clavicle had what doctors call a minimally displaced fracture, correct?

A. That's correct.

Q. And a minimally displaced fracture, Doctor, means that the bones are very close, they are not far apart; is that fair to say?

A. Yeah, that's fair to say.

Q. And that is a good prognosis for healing when the bones are very close and nondisplaced; is that fair to say?

A. That's fair to say.
Q. And in fact, the only treatment that Emily had for the clavicle was she wore a sling for a couple of weeks, correct?
A. That's correct.
Q. And then the clavicle healed, correct?
A. That's correct.
Q. And she had x-ray of her left shoulder, and that was completely normal, correct?
A. That's correct.
Q. The reality was, after a short period of time, you were not treating her for any physical injuries; isn't that correct?
A. That's correct.
Q. The first time you saw Emily post accident, after the derailment, Doctor, was it the 31st, or was it the 22nd?
A. It was the 22nd.
Q. Was there a full record made of the 22nd, or was it an abbreviated record in reference to you, Doctor?
A. I'm sorry. I don't understand.
Q. Yeah, because it is a lousy question, that's why you don't understand.
On the 31st, you have notes of your treatment, on December 31st of 2017, correct, Doctor?
A. No. That's -- it's actually from the 22nd. That's

the problem with Epic.

Q. That's what I am asking.

A. Yes.

Q. So what I am reading as the 31st and only a partial entry of the 22nd, is all of the 22nd?

A. That's all of the 22nd, yes.

Q. Thank you for clearing that up, Doctor. I appreciate that.

So you saw the plaintiff for the first time four days after the accident -- four or five days after the accident?

A. Yes.

Q. And prior to that, you hadn't seen the plaintiff for about -- I think it was about a year and a half; is that fair to say?

A. Yeah, that's fair to say.

Q. And I think, generally speaking, you were seeing her prior to the incident when she was younger, you were seeing her every year and a half, two years; is that fair to say?

A. That's fair to say. She didn't come in often, no.

Q. So I'm going to go to the notation, if you could, that's in my thing; it says the 31st. It is actually December 22nd, 2017, correct?

A. That's correct.

Q. So this is a few days after the incident, correct?
A. That's correct.
Q. And you noted that she had abrasions on the forehead, which required three stitches, remember?
A. Yes, I do.
Q. And is it correct that -- did you remove the stitches at that time?
A. I did.
Q. And some of them were already dissolving by that time, correct?
A. Yes, they were.
Q. And you were aware that she had had multiple CT scans while she was in the hospital, correct?
A. Yes.
Q. Had you ever reviewed the hospital records that she had gone to for the accident?
A. Yes.
Q. So you were aware she had multiple CT scans and x-rays, including a CT scan of the head and all the CT scans, all the x-rays were all negative with the exception of the minimally displaced clavicle, correct?
A. Yes.
Q. And in fact, Doctor, you wrote in here, quote, "She had a bit of bruising but was otherwise lucky other than a broken clavicle." Do you see that?

A. Yes.
Q. And in addition, she did not request pain pills, correct?
A. Correct.
Q. So four days after the accident, she is not requesting any pain pills, correct?
A. Correct.
Q. And you indicated that she had, in your words, a fairly consistent headache, but not yet concentration issues, correct?
A. Correct.
Q. And there was nothing surprising about the fact that she had headaches since she had a concussion, correct?
A. Correct.
Q. We don't -- you don't know how long Ms. Torjusen lost consciousness, if at all; is that correct?
A. I wasn't there so I wouldn't know if she lost consciousness. The records from the outside hospital said she did, and the patient said she did.
Q. All right. But you don't know the length of time?
A. No.
Q. Now, she indicated to you that she had some mild dizziness -- occasional mild dizziness and nausea, but this was improving, correct?
A. Correct.

Q. You recommended Tylenol and Advil, correct?
A. Correct.
Q. If needed, correct?
A. Correct.
Q. And you told her at the time that considering that she had had the concussion, it would be possible or not unusual that she might have symptoms from the concussion from a few weeks to a few months, correct?
A. Actually, I said a couple of months. It doesn't say anything about weeks. A couple of months.
Q. I'm sorry. A couple of months. And that is sort of the normal course of the type of concussion she had, correct, is a couple of months?
A. Yes.
Q. At that time, you did not refer Ms. Torjusen to a neurologist, correct?
A. No.
Q. And a neurologist would be the subspecialty from internal medicine. You are an internist, correct?
A. That's correct.
Q. And internal medicine -- I am hearing my father -- internal medicine covers everything?
A. That's correct.
Q. But there is a subspecialty, neurology, that would deal with injuries, including injuries such as a

concussion, correct?

A. Actually, no, not correct. May I qualify?

Q. Of course.

A. So, yes, neurologists tend to deal with brain functions, nerves, head, yes. In our area, neurologists do not, as a general rule, see patients with concussion.

Q. Okay. Would internists?

A. Yes.

Q. Regardless, after the four days after Ms. Torjusen got out of the hospital, you did not refer her to anyone at that point?

A. No.

Q. And, in fact, I believe you testified in your deposition that if you thought it was medically necessary for you to refer her to anyone, you would have done it, correct?

A. Yes.

Q. So you did not think it was medically necessary to refer her to anyone; is that fair to say?

A. At that time, yes.

Q. Well, you never referred her to another doctor; isn't that correct?

A. That's correct.

Q. So you never thought it was medically necessary to refer her to another physician, correct?

A. No. No.
Q. You just said you would have if you thought it was medically necessary, and you also said you never did?
A. Um-hum.
Q. Is that correct?
A. That's correct, because she had already seen one.
Q. She had seen another physician or she had seen a therapist?
A. The neuropsychological testing. If you want to clarify, would I have sent her to another physician? No. Other medical services? Yes, if she hadn't sought out the care herself.
Q. I want to talk about that. Did the patient -- did this individual come to you and say: I want a neuropsychological exam?
A. No, she did not.
Q. I mean, would it be fair to say most individuals -- most lay people aren't really familiar with what a neuropsychologist is; is that fair to say? Most of your patients, would that be fair, Doctor?
A. That would be fair.
Q. Do you know where she got the idea of asking for a referral to a neuropsychologist?
A. I got the impression it was from her mother.
Q. Do you know where her mother -- do you have any

impression as to where her mom would have gotten the idea that she needed to see a neuropsychologist?

A. I do not.

Q. Now, you wrote a letter -- you had anticipated, look, you might have some problems with concentration, I recommend I write a letter to your college, correct?

A. If she needed it, yes.

Q. If she needed it. So you weren't even sure she needed it at that point?

A. No.

Q. But you wrote a letter anyway, correct?

A. Yes.

Q. And you only wrote the one letter. In the course of the four years, you never renewed it, never sent another letter?

A. That's correct.

Q. I apologize. I am confused. Did you give her a prescription after that first visit?

A. I did not.

Q. Just so the jury understands, four days after the accident there is no referrals and no prescriptions and no other treatment actually recommended at that point, correct?

A. Recommended at that point, yes.

Q. Now, the next time you see Ms. Torjusen is seven and

a half months later, correct?

A. That's correct.

Q. And that would have been on July 16th, 2018, correct, Doctor?

A. Yes.

Q. So as far as you know, the patient goes seven and a half months post-derailment without seeing another physician; is that correct?

A. That's correct.

Q. And there was a specific reason why you saw her on that visit, it's because -- excuse me, Doctor -- she wanted a checkup because she was going to France, correct?

A. Yes.

Q. So she came to you specifically because "I'm going to France so can I have a check up"; is that fair to say?

A. And also to discuss some issues, yes.

Q. And your understanding is that she was going to France for a semester abroad, correct?

A. That's correct.

Q. At that point, there was a discussion about anxiety, but she said she did not think -- she, Ms. Torjusen -- at this point, seven months after the accident, said she didn't think she needed medication for the anxiety, that she was managing it herself, correct?

A. That's correct.

Q. So you didn't prescribe her anything for the anxiety, correct?

A. I did not.

Q. And the main post-concussive symptom she was having, she was having some problems concentrating, she said; is that correct?

A. That's correct.

Q. Had you prescribed something at that point for the concentration?

A. Yes.

Q. That's the Concentra (sic)?

A. Concerta.

Q. Concerta. I apologize. I take it you saw it as a very positive sign that Ms. Torjusen now, seven months after the incident, was going to go by herself away and study in another country?

A. I didn't really consider it a positive or negative sign.

Q. Certainly for a young individual to study abroad in another country by themselves, that can cause some anxiety, can't it?

A. Yes. I would say yes.

Q. Anyway, you certainly had no objections to her going to another country by herself to study, correct? You had no objections?

A. Yeah, no objections at all.
Q. By the way, she told you that she would be -- that her headaches had improved actually, correct?
A. Yes.
Q. And in fact -- am I wrong, Doctor, I don't see anything in your examination review of systems that she was having any dizziness, any light sensitivity, any balance problems; is that correct?
A. That's correct.
Q. So she was having -- in fact, I think she said -- and she had no depressive symptoms, correct?
A. That's correct.
Q. And infrequent headaches, correct?
A. Um-hum.
Q. No visual changes, correct?
A. Correct.
Q. She said she complained about some mild back pain; is that correct?
A. That's correct.
Q. And you said you didn't think it was related to the accident, correct?
A. Yes.
Q. Now, she also discussed with you something that her lawyers were suggesting, correct?
A. Yes.

Q. So at that visit, your patient told you that her lawyer thought it would be a good idea to get a DTI, correct?

A. That's correct.

Q. Does that happen frequently that you have patients coming in getting treatment recommendations from their attorneys?

A. Actually, yes, it does.

Q. It happens all the time?

A. Yes.

Q. You didn't order the DTI?

A. I did not.

Q. You had no interest in getting a DTI and would never have ordered it yourself, correct?

A. Well, no. I actually find them very interesting, but I could never get insurance to cover it.

Q. Doctor, did you testify under oath in your deposition that you never would have ordered it?

A. That's correct.

Q. And, in fact, you didn't get the report of the DTI until two and a half years after it was conducted, correct?

A. That's correct.

Q. And it would have had absolutely no value to you in your treatment of the plaintiff, correct?

A. Well, it confirmed some things I observed. So I did find it valuable.

Q. Well, did you testify it would have absolutely no value? Did you testify under oath it had no value to you in your treatment of the plaintiff?

A. True.

Q. Did you say that under oath?

A. Yes.

Q. By the way, the evidence of the memory problem she was having, she said she forgot her clothes in the car?

A. Yes.

Q. You did a physical examination that day and it was completely normal, correct?

A. Yes.

Q. And the lawyers sent you the forms to fill out to get the DTI, which you did not order, correct?

A. That's correct.

Q. Did you -- again, I am a little confused with the way the chart -- and I apologize. Was medication ordered on that visit?

MR. PETRU: Which visit are we on now?

BY MR. BONVENTRE:

Q. I'm sorry. July 16th, 2018. Sorry.

A. No. Because the patient -- there is a phone call from the patient. I can read it if it is interesting or

if you want it, that she wanted medication for concentration, but she found out from the consulate in France that it was -- they need -- they advised anyone taking medication to France should have the note for the prescription from the doctor. Adderall, for example, was illegal. Those prescriptions were problematic in France.

Q. So she spent time in France -- in fact, do you know where she went after France, by the way?

A. I do not.

Q. So you are not aware that every year in France or eight months or nine months, she then spent four or five months in Cairo, you are not aware of that?

A. No. I am, yes.

Q. So within a year or so after the accident, she was able to go to France for a year by herself and then to Cairo, Egypt by herself for four or five months, correct?

A. Yes.

Q. And apparently she was able to do that without Concerta?

A. Stimulant medication, yes.

Q. Now, Doctor, you next saw her over a year later on September 23rd, 2019?

A. That's correct.

Q. And she told you that she, quote, was traveling a lot, correct?

A. Yes.
Q. And she discussed some intestinal issues at that time, which we don't need to talk about. But she did discuss that?
A. Correct.
Q. And you did a physical examination, correct?
A. Correct.
Q. And I believe once again your physical examination was completely normal, correct?
A. Yes.
Q. And the -- in the part where it does the physical exam, the form, like every visit there, it says "psych," you say "alert and oriented, normal affect," correct?
A. Correct.
Q. What is an affect?
A. How someone presents themselves.
Q. So there was nothing about the way she presented herself that you put down at all in that note on September 23rd of 2019, correct?
A. That's correct.
Q. Do you know a John Randalls, a Dr. John Randalls?
A. Yes.
Q. And he is another doctor at the Vancouver clinic?
A. Gastroenterology.
Q. You are aware that he saw the patient on May 14th of

2020, correct?

A. I actually am not aware.

Q. You are not aware. So you don't remember what he wrote down in terms of his examination?

A. I do not remember, no.

Q. Could you go to -- could you go to the entry for August 26th of 2020? Do you see that note, Doctor?

A. I do.

Q. Was the patient at your office on August 26th of 2000 (sic)?

A. No, she was not.

Q. You did have -- I don't know, would you call it a consultation on that day?

A. Yes.

Q. But the consultation wasn't with a doctor, it was with Ms. Torjusen's attorneys, correct?

A. Correct.

Q. And they called you up, correct?

A. Correct.

Q. And basically asked you if you would be willing to testify, correct?

A. Actually, per my records, it was just talking about her issues.

Q. Could you look at the next page?

A. Okay.

Q. Did they ask you if you would testify?
A. Yes, they did.
Q. Before that, going back to the earlier page, Doctor, if you would.
A. Sure.
Q. They advise you -- they advise you what the patient's symptoms were, correct?
A. I'm sorry.
Q. Do you see "attorney for plaintiff patient," and then they said "lost friends." Do you see that, "lost friends"?
MR. PETRU: It doesn't say --
BY MR. BONVENTRE:
Q. "Has lost friends." That's what it says.
A. Yes, it does say that. But I didn't -- I don't know if they said that or we were just talking in general. I didn't document --
Q. Is there any other place in your medical records prior to that visit where you indicate in any way, shape, or form that Ms. Torjusen has, quote, lost friends?
A. No, there is not.
Q. So you got that information from the attorneys, correct?
A. At that point, yes.
Q. And they asked you -- they asked you if you would

testify regarding the differences between her personality now and before, correct?

A. Correct.

Q. And is it fair to say that up to this point, there was nothing in your records that indicated that there was a difference in her personality, other than you are indicating she was obviously anxious, correct?

A. Correct.

Q. On that date, did you say to the plaintiff's lawyers, gee, before I'm going to testify or find out how she is doing, I need to examine her again?

A. Yes, I did.

Q. You did say that. When was the next time you saw her?

A. It was later that year.

Q. Was it the 21st? No?

A. No.

MR. PETRU: October 9th.

THE WITNESS: Yes, it was the October 9th visit.

BY MR. BONVENTRE:

Q. October 9th. Okay. Hold on one second, Doctor. Just so I understand it, Doctor, on October 9th, the patient now -- this is when the patient -- when you wrote down that the patient missed a whole semester of college?

A. When I wrote down that the patient told me, yes.

Q. But you don't know if it is accurate or not?

A. I do not.

Q. So you did a review of systems on that date, correct, on October 9th of 2020?

A. Correct.

Q. And the only thing you put down was that she, quote, has infrequent headaches, correct?

A. Correct.

Q. The review of systems otherwise was completely normal, correct?

A. Correct.

Q. And then you also did a physical examination on that date, correct?

A. Correct.

Q. And that physical examination was totally and completely normal, correct?

A. Yes.

Q. And on this date you, quote, did a trial of -- is it Buspar?

A. Buspar.

Q. Citalopram?

A. Citalopram.

Q. I apologize. Is that the first time, now three years after this accident, that you prescribed this medication?

A. That I prescribed that, yes.

Q. Do you know if she took it after you prescribed it?
A. She said she did.
Q. Did she have a tendency not to -- you would make suggestions and she wouldn't always follow them; is that fair to say?
A. Not -- no, not any different than any other patient.
Q. A lot of your patients don't follow --
A. Yep.
Q. Okay. You saw the patient again, and for the last time, on May 17, 2021, correct?
A. Correct.
Q. So on the last time, just so the jury understands, the last time you saw Ms. Torjusen was seven or eight months ago, correct?
A. That's correct.
Q. And she told you at the time that she was planning to move to Cairo, correct?
A. I don't think move. She was planning to go back to Cairo.
Q. Okay. Do you know where she lives right now, Doctor?
A. I do not.
Q. So you don't know that she is actually living in Cairo?
A. I don't.
Q. Do you know what she is doing -- do you know what she

is doing in terms of her employment?
A. I do not.
Q. Do you know how she did in school at the UW?
A. I don't have her grades, no.
Q. Do you have any sense, she did great, she did lousy?
A. The only thing I have is that she was frustrated. She mentioned like, for example, took Arabic in France and had a hard time of it.
Q. That semester she took Arabic in France, her GPA, do you know if it was 3.7, 3.9?
A. I have no idea.
Q. In any event, the last time you saw her was about eight months ago, correct?
A. That's correct.
Q. And she told you that the headaches have gotten better?
A. That's correct.
Q. And that she plans to go to Egypt, correct?
A. Correct.
Q. And you did a physical examination, correct?
A. Correct.
Q. And your physical examination was, once again, completely normal, correct?
A. That's correct.
Q. And you noted that she was alert and oriented and had

a normal affect, correct?

A. Correct.

MR. BONVENTRE: I think that may be it, Doctor. That's all I have, Doctor. Thank you very much for your time. I appreciate it.

I would like to move into evidence Plaintiff's Exhibit 7, which is the letter that Dr. Spohr wrote that has been referenced. I don't want to publish it now, but I would like to move it into evidence.

THE COURT: Any objection to 7?

MR. BONVENTRE: No objection.

THE COURT: It is admitted. It may be published.

(Exhibit No. 7 admitted.)

MR. BONVENTRE: We will publish it later.

REDIRECT EXAMINATION

BY MR. PETRU:

Q. It is always interesting when an attorney meets with a physician -- a treating physician to get some information to find out what's going on and it becomes a big deal.

MR. BONVENTRE: I object, your Honor.

MR. PETRU: It was a big deal, counsel. You just mentioned it.

MR. BONVENTRE: I assume we are supposed to have questions, your Honor.

THE COURT: Overruled. You may proceed.

BY MR. PETRU:

Q. Did you welcome seeing Emily again to catch up with her, find out what was going on?

A. Absolutely.

Q. Did anything about the conversation that Mr. Levy and I had with you change or alter any of the opinions or conclusions that you generated in your care for Emily from December 18th, 2017, to the present time?

A. No.

Q. Did any of the questions that counsel asked you alter any of the opinions or conclusions that you expressed during your direct examination?

A. No.

Q. I would like to just correct a couple of things. If you can go to your December 22nd note. Tell me when you're there.

A. Yep.

Q. Under the "subjective" section, counsel asked you whether you gave her any pain pills. Can you please read on the second page, first line, the complete sentence, beginning with "she has"?

A. "She has pain pills and is not requesting anything additional."

Q. So she had pain pills. She had pain pills from the

hospital. They were functional and she didn't ask for any additional pain pills, correct?

A. Correct.

MR. BONVENTRE: Objection, your Honor.

THE COURT: Overruled.

MR. PETRU: Those are all the questions I have.

MR. BONVENTRE: No questions, your Honor.

THE COURT: All right. Thank you, Doctor. You may step down.

MR. PETRU: Your Honor, we have another witness who is standing by remotely. We can begin if we can get the connection set up.

THE COURT: How much time --

THE CLERK: My computer is down.

MR. PETRU: Apparently, the Judge does not have total control here.

THE COURT: You don't have another live witness?

MR. PETRU: We don't have another live witness.

THE COURT: We are going to take an early break here for the day and ask you to return here tomorrow at 9:00. Please do not discuss the case. We will get the technical problems solved, I'm sure.

(At this time, the jury exited the courtroom.)

THE COURT: All right. Tomorrow then the witnesses are going to be --

MR. PETRU: Dr. Scovel first up, remotely. We will have Patty Torjusen. I'm not sure of the order. Patty Torjusen live. Daniel Healy remotely. Unfortunately, Dr. Johns who is available -- she is the one who is in the hospital -- remotely, and Emily Torjusen.

THE COURT: All right. We might finish testimony tomorrow?

MR. PETRU: If I can control everything, yes. But I can't.

THE COURT: In any case, let's plan on a brief conference on final instructions tomorrow at noon. We will say 1:15.

MR. PETRU: That is brief.

THE COURT: Well, I don't know that we have a lot of disputes to take up.

MR. BONVENTRE: I'm sorry, Judge. Before you leave, can I raise one quick issue? I don't want to sandbag counsel. I want to raise it tonight. Dr. Johns is, I believe, another psychologist, therapist.

MR. PETRU: Yes.

MR. BONVENTRE: We have already had multiple doctors talk about PTSD. We are going to have Dr. Scovel as well. The court rules talk about duplication. My sense is the Court has already indicated you are going to

allow Dr. Johns to testify, but I would ask there not be a lot of duplication of what has already been said, and further what is going to be said tomorrow with Dr. Scovel.

THE COURT: Of course, I did say that. Where there is cross-examination challenging conclusions and findings of existing doctors, rather than have it be rebuttal, I think it is appropriate. I do think there doesn't need to be going over a lot of the same ground.

MR. PETRU: I agree, your Honor. We have the burden of proof. Counsel has not stipulated that she has PTSD or a traumatic brain injury, so we have to prove that. If they would stipulate to that -- I think it is obvious, but if they stipulate to it, we don't have to do it, but they haven't.

THE COURT: All right. We will see you in the morning at 9:00.

MR. BONVENTRE: Thank you, your Honor. Have a good evening.

(Recessed.)

C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Barry Fanning

BARRY FANNING
COURT REPORTER